

CHEMIST & DRUGGIST

The newsweekly for pharmacy

September 22, 1984

a Benn publication

GP dispensing applications outnumber pharmacists' almost 3:1

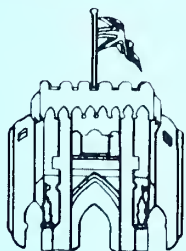
LPC petition delays IoW supermarket pharmacy

All Unichem sundries at Sheffield

EPOS 84: a way ahead for pharmacy

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COMMENT

How curious that the first relatively complete set of statistics on the first year of the Rural Dispensing Committee's operations should have come, not from the RDC, but from the annual report of the Pharmaceutical Services Negotiating Committee. Curious but not surprising.

The RDC is contemplating releasing its own report at any time but will not necessarily so do. That Committee has stoically refused to give to the Press any details of individual cases known to it, other than the bald decisions taken — all in fact, that are available in the PSNC report. And while a six month progress report was given by chairman Sir Alan Marre in a *C&D* interview (September 24, 1983, p550), the PSNC figures may well be the most complete set that are published.

Happily, PSNC's financial year co-incides with the RDC's inaugural year. Both began on April 1, 1983, so it is able to give an outline of the RDC's progress. What the bald statistics show is that the medical profession so far has sought to take greater advantage of the Clothier Regulations than pharmacists. Fifty-four doctors applied to dispense in controlled areas in the RDC's first year compared with just 20 pharmacists. It may be that the doctors' enthusiasm to dispense, evident in the number of applications may be tempered by time or by their

success rate. However, with 21 out of 54 applications granted in full, eight in part and with 18 to be decided, that seems unlikely. Pharmacists have also had a near 50 per cent success rate with another 25 per cent of cases to be decided as of March 31.

What matters is that there is an agreed procedure to decide contentious dispensing cases in rural areas. It is up to the professions to use the regulations as best they can — and unless one side discovers an improper or unforeseen advantage — to use them to advance their own cause.

Mr Patten's advice to some pharmacists last week in his address to the Southampton Conference, to recognise the fact that the long argument over the supply of medicines in rural areas has largely been resolved could, perhaps, be taken to refer to the still active Rural Pharmacists Association. "He sadly misjudges the feelings of rural pharmacists if he thinks we will accept that so-called doctor dispensing is an adequate substitute for a professionally run pharmaceutical service" (see RPA secretary John Davies, p514). But he would be better advised to whisper the same words in the ears of the newly established Dispensing Doctor Association which is poised to sally forth from the fields on behalf of its 1,000 plus members to rail against the Clothier Regulations.

More GPs than MPs on dispensing trail

During the first year of its life the Rural Dispensing Committee received almost three times as many applications from doctors to dispense in rural areas as it did applications from pharmacists to dispense in controlled localities.

The RDC received 20 applications from pharmacists to dispense during the year. By the year-end, March 31, nine applications had been granted, three refused, three withdrawn and five remained to be decided. At that time appeals in respect of five decisions had been lodged with the Secretary for Social Services: three appeals had been rejected and no decision had been notified to the Committee on the other two.

These statistics are contained in the annual report of the Pharmaceutical Services Negotiating Committee which has two members, chief executive Mr Alan Smith and vice-chairman Mr David Coleman, on the RDC. Its year runs from April 1 to March 31. Co-incidentally, the Clothier Regulations on rural dispensing came into force on April 1 last year. Since then the RDC has met monthly with appointed subcommittees making 18 local visits in the inaugural year.

PSNC reports the RDC received 54 applications from general medical practitioners for outline consent to dispense during the year. By the end of March, 18 applications remained to be decided, but 21 had been granted in full, eight had been granted in part only, three had been refused and four had been withdrawn. The Secretary for Social Services had rejected one out of the four appeals made against RDC decisions by March 31 and had, at that time, not notified the RDC of his decision in the other cases.

The RDC was required also to consider three cases where the opening or relocation of a pharmacy within an urban area affected dispensing patients living within a rural area, but who are within one mile of the premises from which the pharmacy would operate. PSNC says that in all these cases the RDC decided on an appropriate period of notice for ending GP dispensing for the affected patients.

During the year the RDC were notified by 21 Family Practitioner Committees of 37 decisions on the rurality of defined areas. In 19 of those cases the period for representations to the Committee passed without any such representations being made and the FPC decision therefore came into effect: in six cases the period for representations had not expired by the end of March.

Of the remaining cases, in nine the local decision on rurality was contested in whole or in part. Of these, on March 31, five appeals had been rejected, one upheld and three were under consideration.

In three remaining cases the decision on rurality was not challenged, reports PSNC, but the RDC received an application to impose conditions which would reduce the impact of that decision on existing doctors and pharmacists.

PSNC says that, in due course, the RDC intends to conduct a retrospective review of a number of the cases it has considered, with the intention of assessing the extent to which the impact of a decision proved to be correct, and if not correct, the extent of the difference. Such a review would help the RDC to review future cases.

PSNC chairman David Sharpe in his statement to PSNC's annual report, thanks the RDC members and their deputies for the "vast amount of work involved and the satisfactory outcome of the numerous cases referred to the RDC during its first year of operation."

Payment agreed in 1983-84 for compensation to GPs for ceasing to dispense is £77,040. However, that sum is usually paid in annual instalments over five years: the sum paid out in 1983-84 is £8,554 and will be £15,408 for the next four years in respect of this year's agreed sum.

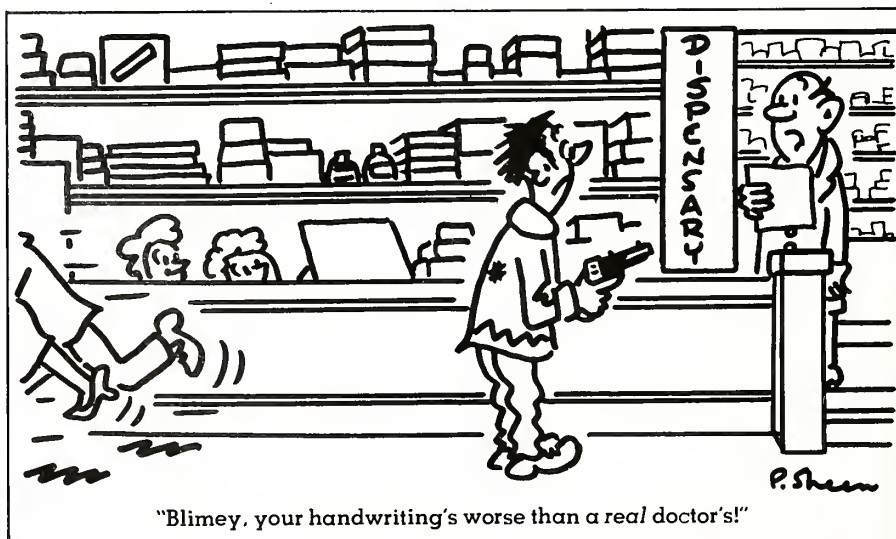
PSNC's income and expenditure account for the year shows an operating deficit of £76,348. "This deficit has arisen mainly due to: an increase of £109,579 in professional fees incurred on litigation against the Secretary for Social Services with regard to the recovery of discounts: the employment of pharmacist observers, other professional costs in connection with the 1983 remuneration inquiry, and consultancy fees paid to Hay MSL and Coopers and Lybrand for professional advice on the proprietors notional salary and net profit margin issues."

Payments were made to 404 pharmacies in 1983 under the Essential Small Pharmacies Scheme, totalling £375,000.

During the year PSNC's Central Checking bureau carried out routine checks on between 1½ and 2 per cent of all prescriptions dispensed in England and Wales. The checks revealed an overall cash underpayment of 0.032 per cent on the 5.2 million script examined, value £21.5m: the DHSS will correct the underpayment. Special checks carried out for 230 contractors showed an average underpayment of 0.049 per cent.

NI statistics

In June, chemists and appliance suppliers in Northern Ireland dispensed 1,123,024 prescriptions (696,812 forms) at a gross cost of £5,388,268.73 with an average cost of £4.79 each.



"Blimey, your handwriting's worse than a real doctor's!"

IoW supermarket pharmacy delay

The opening of an in-store pharmacy in the International Stores branch at Newport on the Isle of Wight, has been delayed, until next year at the earliest, in the face of strong local opposition.

A campaign against its development has been mounted by the IoW Local Pharmaceutical Committee, which has the support of the island's family practitioner committee and local doctors and dentists (*C&D*, August 4, p200).

A petition of 6,350 signatures in support of the protest has been collected and sent to the managing director of International Stores, Mr D. Caulfield. "Not one person supported International's proposed move, and many were quite

worried that their 'neighbourhood pharmacy' could be affected by such a trend," Mr Tony Williams, secretary of the LPC, told *C&D*.

The decision to postpone the opening and rethink the project comes at a time when International have just announced a £250 million development programme, with plans for 100 new stores in the next five years, and with "at least ten" in-store pharmacies by the end of next year. The company currently operates pharmacies in its Torquay and Weymouth branches which a spokeswoman said were "performing well enough for us to be considering opening more." A third is scheduled to open in Brentford, Middlesex on October 8.

International stress that new pharmacies would only be opened where there was "an opportunity to improve the service to a community or in an area where they might be poorly served."

President backs hospital claim

The out-of-hours dispute in the hospital service has gone on far too long and should be resolved immediately. Dr Hopkin Maddock told pharmacists at the Conference banquet last Wednesday.

Health authorities are embarrassed that pharmacists are the only persons in their employ treated in such a parsimonious manner, he said. "It must be obvious, even to the Department of Health, that hospital pharmacy is steadily increasing its contribution towards the cost effective use of medicines."

Dr Maddock restated Council's support for the staff at the Herriott Watt

School of Pharmacy, and the university in its attempts to retain its pharmacy degree course. Cuts that had already been made in the university sector meant that manpower reductions could be made without closing any school of pharmacy.

The president also spoke of the Society's role as an enforcement authority — "a role that has been carried out over the past 100 years without cost to any government." Less than half the work of the inspectorate is now spent within pharmacies and the pharmaceutical profession, Dr Maddock said.

Pharmacists can be proud of the contribution they are making towards curtailing the drug menace, he said. "Whenever drug abuse is debated, never is the finger pointed at the pharmaceutical profession as a source of supply in this appalling problem."

Kilburn siege man charged

The man arrested at a Kilburn chemists last week (see *C&D* September 15, p435) has been remanded in custody until September 21 after appearing at Willesden Magistrates Court.

Mr Roy Terence McNeil, aged 27 and unemployed, of Kentish Town made no application for bail. He is charged with robbing Mr Dilip Patel of a quantity of drugs and £119 cash at Bliss chemists in Willesden Lane on September 11.

He is further charged with possessing a handgun at the same time and assaulting a woman and unlawfully and injuriously imprisoning her for two and a half hours.

Sack follows cut in hours

A pharmacy assistant, sacked for refusing a cut in working hours, was not unfairly dismissed, an industrial tribunal has ruled.

The tribunal in Glasgow heard recently that Mrs Bridget Thomson, Waggon Road, Brightons, Falkirk, was working as a dispensing assistant at J. Goodchild's pharmacy in Pretoria Place for 23 hours one week and 26 hours the next.

When the business was taken over in May by pharmacist Mr Michael Cohen he decided he needed a full-time worker to attend to the counter and a part-timer to work 16 hours a week. He told Mrs Thomson that the shop would be open longer but she did not want to work any more hours, nor did she want the job of part-time assistant which involved a substantial drop in hours and wages.

When she told Mr Cohen that she wanted to work the same hours she had worked previously, he told her this was unacceptable. The tribunal ruled that Mrs Thomson was dismissed because of economic and organisational reasons and her dismissal was not unfair.

■ The BBC2 series "Another Six English Towns," is to feature a pharmacy in its September 23 programme on Bury St Edmunds.

The building, currently occupied by Savory & Moore, has been in continuous use as a pharmacy since 1781. The timber-framed structure is probably of 15th century origin and a foundation wall has been dated to the 13th century.



Pictured at the Conference banquet are Dr Hopkin Maddock, president of the Society (left), Mrs E. Joan Maddock, Admiral Sir Desmond Cassidi, who proposed a toast to the Conference and Society, and Mrs Jean Denton, female executive of the year and science chairman Professor J.T. Smith, both of whom gave speeches

Unichem reply to bond critics

Wholesalers who slam Unichem's Unibond scheme are doing so in "desperation," claims managing director Peter Dodd. "It is too good for any independent pharmacy to miss."

Mr Dodd says the criticism of the scheme from Vestric and Macarthy's is predictable. "When Unichem announce further improvements in profit distributions, competitors squeal. In this case I believe there is little else they can do other than try to pour cold water on the scheme."

"As Macarthy's say, the Unibond scheme looks good with an extra £4m thrown on the table. But to criticise the scheme on the ground that an individual pharmacy does not know how much 'jam' it will get, and that the Department could claw it back anyway, suggests desperation."

Mr Dodd admits he cannot predict exactly how much the scheme will give to each individual participant other than it would be "substantial." As Macarthy's imply, he says the "jam" is top of an already excellent cake with monthly and annual profit sharing the main ingredients.

"At the end of the day, our profits belong to our shareholder members. The larger we become, the larger our profits and the more each member benefits. Unibonds are a perfect example of this philosophy."

"The time has come when every independent pharmacy should be a joint owner of Unichem. There is no gamble. If the scheme helps in this crusade, only independent pharmacy will win," he added.

□ In an analysis of the pharmaceutical market entitled "Unichem Turn The Screw" brokers Hoare Govett say the introduction of Unibond indicates that Unichem intend to further exploit the strength of their position.

"Although the level of payout is currently unquantifiable and for some may be relatively small, it nonetheless represents an additional incentive to pharmacists to direct their business towards Unichem, even though doing so may involve a three-year commitment" they add.

"This, together with a possible overall increase in sales, could provide Unichem with a significant competitive edge. For competitors to retaliate on an equal basis would be difficult."

1984

CHEMIST & DRUGGIST CHEMIST ASSISTANT OF THE YEAR COMPETITION

Time. Ladies . . .

"Time. Ladies and gentlemen please!" Well almost. Will any chemist assistants out there who are still hiding their skills under bushels, please dig out their entry forms for the 1984 *Chemist & Druggist* Assistant of the Year competition, and return them before the September 30 closing date.

Of course, we realise that you may have lost them or that your boss may have failed to convince you that you should enter. In the first instance, simply contact C&D direct by telephone (0732 364422, ext 238) and we will send a form by return. Alternatively, contact your local NPA training group, or representatives of sponsors May & Baker or Vichy (UK).

If you have completed the NPA training course and have been awarded the certificate, you need fill in only part 2 of the application form. If your training has been less formal, in-house "watching

Nellie" maybe, then you must complete the whole form. Your experience may be every bit as good as your "certificated" colleagues, so do not be deterred. Enter! Use the entry envelope provided or the Freepost address on the form.

Remember, first prize is £1,000 with £500 for the second prize and a third prize of £250. And for all the finalists, we are sure there will be a great day at the Sheraton Skyline Hotel (close to London's Heathrow airport) on November 29. So, look out those entry forms, and sign up. You have just eight days left.

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BPC — what the papers say

The opening session of the British Pharmaceutical Conference in Southampton generated a number of reports in the national press.

"Pharmacists given hint of more power," headlined the *Times*, leading with a report of the speech of Mr John Patten, the Parliamentary Secretary for Health. "Doctors 'ignore value of pharmacists',"

said the *Guardian*, "GPs' prescription errors 'costing NHS millions'," led the *Daily Telegraph*, both reflecting points in the speech of the Pharmaceutical Society's president, Dr Hopkin Maddock.

The tabloids focussed on doctors' handwriting; "Doctors' scrawl 'is a health risk'," in the *Daily Express* and an "illegible" handwritten "This could endanger your health," above the report in the *Daily Mail*, who also asked the opinion of a graphologist.

The *Daily Express* followed up the handwriting story the following day with the Giles cartoon, reprinted below.



"Lady! I've been reading doctors' handwriting all me life — your prescription says '24 Teddy Bears, 1 doz. horse pills, and a box of mystique eyeshade'."

Ads surveyed — half break code

Students at the London School of Pharmacy recently found that over half of a sample of drug advertisements breach the industry's code of practice.

The survey made national Press headlines last week and received television coverage on BBC's *Newsnight*, but it has been described by tutors as simply a teaching exercise and not a survey intended for publication.

Students at the School of Pharmacy were asked to comment on the compliance of advertisements with the Association of the British Pharmaceutical Industry's Code of Practice. Of 74 advertisements scrutinised 42 were in breach of the code.

The exercise was co-ordinated by Dr Hilary Pickles, a senior medical officer in the Department of Health's medicines division. Dr Pickles is also an honorary lecturer at the School of Pharmacy.

Dr Michael Simmons, senior lecturer in the department of pharmacology, told *C&D* the results of the survey were interesting but emphasised that the students were not experts, merely informed observers. It is understood that most of the infringements were technical involving minor rather than major transgressions.

The ABPI carries out its own scrutiny, and in 1984, some 2,900 advertisements were checked and only 39 possible transgressions found.

Achromycin recall

Achromycin eye and ear ointment 1 per cent, lot B14694 — 283 is being recalled because of problems with leakage through the nozzle of some tubes.

Stock of the batch is to be returned to wholesalers for credit. Replacement product should be available within eight to ten weeks, say Lederle Laboratories.

For those cases needing urgent treatment a limited stock of Aureomycin ophthalmic ointment and Achromycin ophthalmic oil suspension is available.

■ The Advisory Committee on Dangerous Pathogens has published its first report, providing a national system for the classification of micro-organisms according to hazard. It sets out the essential elements in a model code of practice for micro-biological safety in laboratories and animal containment rooms. *Classification of Pathogens According to Hazard and Categories of Containment from HMSO; £4.50.*

125 years old!

Although I might look it, I assure you there is no truth in the suggestion that I started writing when this magazine began. The idea is preposterous.

Although, as you get older, time does tend to fly, with the years accelerating past. I started some time later.

But like the *C&D*, I recently went browsing through some of my collection of pharmaceutical books. As usual it is the advertisements which catch the eye. A nice one, typical of its time, was found on the front page of the *PJ Formulary*, inserted by Evans Sons, Lescher & Webb, Liverpool and London. They told readers they were "the first house to introduce Counter Adjuncts, many of whose formulae are similar to those in this book." Readers were advised, if not possessing one, to write for the book of "Hawley's Novel Counter Adjuncts." (copiously illustrated).

At the back of this 1903 book were even more delicious examples of the enterprise of the various firms in business then. For example, the Tasmanian Eucalyptus Oil Co Ltd offered "The only reliable eucalyptus," called Tasmanian Globulus, and Platypus Brand! Over the page a firm called Collins published a broadsheet-type advert asking: "Is the oil of Eucalyptus Globulus the best?" Answer: "Emphatically no!" Knocking copy is nothing new, it seems.

Wrong size?

With retail business, size is everything — with price lists, size can be critical. I was interested to read of the struggle between the "Retail Chemist" price list, remembered as the "red book": reasonable enough to use, since being a bound volume it lasted well, but it could never approach the *C&D* for convenience, particularly after inflation took off and weekly price changes became the norm rather than the exception.

For a while I had both, but rather than loyalty being the reason for the survival of this journal, I reckon it was a shrewd appreciation of the retail chemists' needs, and a better identification with them, which swung the battle. I'll tell you one thing: from my knowledge of the past and present editors, I am 100 per cent convinced of their commitment to the survival and prosperity of community pharmacy. They have given people like me a platform, genuinely unfettered by business considerations. I can have a go at named companies, even though they may advertise in the *C&D*, if I feel I have

something worth saying.

The correspondence columns, are open to any pharmacist, whether to blow off steam, or argue a case for his election. And letters which are topical get printed in time to be of use, rather than too late to affect the issue. We have a paper which is easy to read, and is read.

Future?

I liked president Dr Hopkin Maddock's thoughtful assessment of the state of pharmacy following his quickstep through our past history. Unusual for me to find agreement with the president of the Society, but I see no future for us unless we accept that we have to continue to change roles, so as to use the expertise in drugs which is our prime *raison d'être*.

But in down-to-earth practical terms I am busy looking at how my retail shop is trading, with a planned programme of attention to each of four departments to be undertaken over the next year. The first results of six months work have bought a doubling of turnover in one area which is most gratifying.

This week I am going to the Chemex show at Olympia to see what I can see in the way of a packaged health foods deal, some new cosmetic ideas, new photo suppliers, and some shop fitting brainwaves. My aim is to get back to a 50:50 split between NHS and retail, so as to limit my liability, and to raise the profit level somewhat. It's hard work.

Poor cat

Fifi has had an accident, and had to be rescued from an unco-operative neighbour's garden. After repeated calls, we finally heard her plaintive yowl and rushed to the rescue, followed by a fast drive to the vet who said she might survive. The immediate problem was a low temperature and deep shock so we wrapped her up with TLC and an electric blanket and nursed her back to life.

Feeding every two or three hours is enormously difficult with a weak cat. We tried teaspoons, saucers, syringes and then found in the shop the ideal thing for animals. It is the simple soft rubber one-piece ear syringe. You can measure the dose and make sure the creature takes it, yet graduate the flow rate at the same time, all with one hand.

She's picking up nicely now, on a combination of Minadex with Cytacoon every second day, and Grandma's Biostrath and milk three to four hourly for the last five days. I must try some Arnica 6 for the bruising.

OTC acne line from Janssen

Janssen Pharmaceutical are launching a new OTC treatment for acne to coincide with the establishment of their OTC division. (see *Chemex Preview C&D* September 8, p411).

Acnidazil is a Pharmacy only preparation indicated for topical treatment of acne vulgaris available in 20g (£3.99) and trial 5g (£1) sizes. The white, odourless cream contains miconazole nitrate 2 per cent w/w and benzoyl peroxide 5 per cent w/w.

A thin layer of cream should be applied to affected areas each evening for the first week and morning and evening thereafter.

Washing the area with a mild soap and lukewarm water prior to application enhances the efficacy of the medication. Treatment should be continued until symptoms have disappeared (normally between four and eight weeks). In patients below 18 years of age, if particularly prone to acne, improvement may be maintained with two to three applications a week.

Miconazole nitrate and benzoyl peroxide suppress the growth of *Propionibacterium acnes* and *Staphylococcus aureus* in vitro. Benzoyl peroxide has keratolytic and drying properties and reduces the concentration of free fatty acids in the sebum. Clinical and in vitro studies have shown a synergistic effect of the two components in acne vulgaris.

The cream should not be used in patients hypersensitive to any of the ingredients. And it should be kept away from eyes and mucous membranes. Occasionally mild irritation and/or moderate reddening may appear especially at the beginning of treatment. But true contact allergy to benzoyl peroxide or miconazole may be rarely encountered. It may bleach dyed clothing and fabrics.

Acnidazil has a shelf life of two years under normal storage conditions and should be stored away from direct heat.

There is to be an introductory bonus offer and display materials are to be available from Janssen Pharmaceutical Ltd, Grove Wantage, Oxon OX12 0DQ.

Forceval in 15s

Unigreg have introduced a 15 capsule pack of Forceval (£1.55). Distributors: Farillon Ltd, Bryant Avenue, Romford, Essex RM3 0PJ.



While stocks last, a 175g Tabu bath soap is available at £1.15 instead of the recommended retail price of £2.30. A POS outer holds 12 soaps. *Dana Perfumes Ltd, 45a Crusoe Road, Mitcham, Surrey.*

Massage range re-introduced

The Cassa Collection of skin massage products is being re-introduced. The new range consists of five skin care products, available in three colours — ivory, pastel blue and pastel pink. A shower sponge, body sponge, long handled sponge, backstrap and glove are all available — the body sponge and long handled sponge coming with non-friction and friction replacement heads. Packaging is burgundy and cream.

The replacement heads and long handled sponges are available six to an outer, and the backstrap, body sponge, shower sponge and massage gloves twelve come to an outer. Retail selling prices range from £2.75 for a replacement sponge to £5.95 for the long handled massage sponge. *Toiletries consumer products division, Declon Ltd, 83 Manton Road, Earlstrees Industrial Estate, Corby, Northants.*

Two 125ml packs of Headlines, anti-dandruff shampoo and conditioner, are being offered at £0.99 — a saving of £1.11 on the recommended retail price. *Beecham Proprietarys, Beecham House, Brentford, Middx.*



Tambrands roll-out new applicator

Following a town test in Cambridge (*C&D*, April 14 p737) Tambrands are now moving into Northern Ireland and Eire with a round-tipped applicator tampon. The new tampon will replace the current product. The company anticipates rolling-out the new brand nationally within two years. Women's press and radio advertising — the latter in the Belfast and Dublin areas — will support the launch from October 1. The advertising spend is said to be heavyweight. *Tambrands Ltd, Dunsbury Way, Havant, Hants.*

Win a holiday on Weleda

A window display competition with a first prize of a holiday for two in the Algarve is to be run by Weleda in October. To enter stockists have to send a colour print of their Weleda skin & beauty therapy window display attached to their letterhead. Second prize is a video cassette recorder and third prize, a stereo radio cassette player (or their cash equivalents).

At the same time consumers will be offered a free tube of Weleda's moisturising cream when purchasing two items from the range. The tube will be posted to any consumers who send a stamped offer leaflet with proof of purchase. *Weleda (UK) Ltd, Heanor Road, Ilkeston, Derbys DE7 8DR.*

Glymiel update

Glymiel has been repackaged and is now available in a bright plastic tube. Both pack size and price structure remain unaltered (100ml, £0.98). Distributors are *Farillon Ltd, Romford, Essex.*

Weaning booklet

To complement their *Cradle Days* booklet covering the feeding of new-born babies, Cow & Gate have produced a second leaflet, *Weaning to Family Meals.*

The booklet gives guidelines on how and when to wean from breast or bottle milk to cup and solids. It includes photographs by Patrick Lichfield, diagrams and drawings, and is available from *Consumer Affairs Department, Cow & Gate Ltd, Trowbridge, Wilts BA14 8YX.*

Chemist & Druggist 22 September 1984

Men hold key to deodorant sales

The biggest potential for growth in the deodorant market is among men says the latest *Mintel* report.

Worth £90m at rsp, the market has recorded growth in recent years mainly due to the advent of bodysprays — they now take an 18 per cent value and 14 per cent unit share of the market. The report sees their future however as "the great imponderable" and suggests that, although sales are still increasing, there will not be much further growth.

"The prime task is to get more men to use a deodorant at all and there is also scope for increasing frequency of usage among men who do use deodorants but not on a daily basis." While 72 per cent of women use a deodorant at least once a day, the corresponding figure for men is much lower at 40 per cent.

One product development that could encourage more male usage is the stick deodorant. Old Spice was recently joined in the UK market by both Speedstick and Sure Solid. While only worth £2m in 1982 it is a market sector that can be expected to see further growth.

Within the deodorant market women tend to still prefer roll-ons and men aerosols. The last *Mintel* report (December 1981) reported a trend in volume away from aerosols towards a 50:50 split with roll-ons. This trend says the latest report has now been reversed with aerosols taking nearly 60 per cent of the market in value terms and 50 per cent in units.

Excluding bodysprays, Right Guard and Sure continue to vie for brand leadership. The report suggests Right Guard is the biggest single brand with a 12 per cent value share of the market; Sure comes a close second with 11 per cent. Mum continues to lead the roll-on market



Sussex pharmacist, John Meaby, MPS, is winner of the £1,000 top prize in Unichem's Golden Dozen draw for July.

Mr Meaby is pictured holding a fan of £5 notes at his shop in Rose Green Road, Bognor Regis. On hand for the presentation was Unichem director Frank Jamieson (right). Assistants Doreen Boteler, Theresa Wiltshire and Mandy Bull received £100 between them.

with a 21 per cent value share (5 per cent of the total market).

In bodysprays the two Elida Gibbs brands between them now take two-thirds of the market. (Impulse 51 per cent, Vivas 15 per cent). Limara, says the report has a 10 per cent share.

Chemist outlets continue to dominate sales (Boots 30 per cent, independents 10 per cent) although supermarkets and drug stores have been making inroads. Retailers own-brands are flourishing, says the report, and will continue to do so for the next 3-4 years before levelling off at 10-15 per cent of the total market.

Manufacturers continue to spend heavily on advertising with Gibbs, Beechams, Gillette, Smith & Nephew and Bristol-Myers between them accounting for the major part of the £11.9m spend in 1983 (in 1980 the figure was £4.6m). They will have to continue to spend heavily, says the report, to fight the growing threat from own-label in what is an already competitive area.

Scope for new product development should keep the market buoyant, it continues, pointing to the introduction in Australia of a hooded aerosol to target the spray. *Mintel Market Intelligence Report on Men's deodorants, September 1984, 7 Arundel Street, London WC2R 3DR.*

Braun orders win Pharmagen deal

In a Christmas deal on Braun, Pharmagen are offering bonus stock of their other lines with Braun orders of £125 (at trade prices). Stock bonus works out a 12-13 per cent covering, among others, Efamol, Kaopectate, Pretty Polly, Allergan and Pharmaton. Indicated on the order forms are the fastest moving lines in the Braun range and a selection of POS is available free of charge. *Pharmagen Ltd, West Lane, Runcorn, Cheshire.*

Tabmint shelf-life now three years

Tabmint has been reformulated and now has a shelf life of three years.

The reformulated product is light orange instead of the original red. The main active ingredient is still silver acetate. It is soon to be repackaged with an additional pack of 60 pieces to retail at £8.32. *Radiol Chemicals Ltd, Steptfield, Witham, Essex CM8 3AG.*

Symbols for purity and health



Only found on Cantassium vitamins, minerals and diet foods —
the Professional's choice.

Sole chemist distributors Dendron Ltd.,
94 Rickmansworth Road, Watford, Telephone No. 0923 29251.

© Rita Greer

Health foods lose cranky image

The specialist health food sector is overcoming its "cranky" image thanks to the growing interest in healthy eating.

A report, *Health Foods in the UK*, by the Leatherhead Food Research Association suggests the main restraint to growth is the limited numbers of health food stores and High Street locations although "the still widespread public reluctance to enter a health food shop is also an important factor."

The report forecasts there will be 1,500 health food stores in the UK in 1985 — 200 more than in 1983. At the moment there is one shop per 45,000 people in the UK compared to one per 36,000 in the States and one per 22,000 in West Germany.

Some 3,500 chemists now sell health foods and the report suggests it is an area of "great potential" especially the vitamins and tonics market. Worth £45m in 1983 — three times the 1978 figure — chemists dominate 80 per cent of all vitamin and 95 per cent of tonic sales. Multi-vitamins continue to be the biggest single product category. Consumer research quoted by the report suggests 23 per cent of adults in the UK take some kind of vitamin preparation. However only 5 per cent are regular users (compared to 40 per cent in America).

One market which can be expected to see an increasing number of users is sweeteners. Government approval of six new sweeteners in September 1983 is likely to have a profound effect on the market says the report. One forecast suggests the UK table-top market will be worth around £27m by the end of 1984 — an 80 per cent increase on 1983. At the moment only 9 per cent of UK users use sweeteners regularly while sugar consumption per head per annum averages 36.7kg. "Health Foods in the UK." *Moir A. Hilliam, Leatherhead Food RA, Randalls Road, Leatherhead, Surrey.*

Mat finish?

Pretty Polly customers are being invited to collect proofs of purchase of Galaxy Ramblers packs and send them, with a colour negative, to Pretty Polly. In return they will receive a personalised heat-resistant place mat. Three proofs of purchase, or one proof and £0.99 (plus postage) are needed for each table mat. There is a limit of six per customer. *Pharmagen Ltd, Runcorn, Cheshire.*



Beauty Basics are adding three miniature bathing foams — 1 each of peach, lime and vanilla — (£2.50) to the Just Desserts bath range. The bathing foams come supplied in a transparent tube. Also available is a full colour display unit to hold the miniature bathing foam, free with purchases of 72 bottles. *Beauty Basics Ltd, Unit D, 51 Calthorpe Street, London WC1X 0HH.*

Avent ad details finalised

Cannon Babysafe's recently launched Avent range (*C&D* September 15, p447) is to be promoted in baby annuals and the mother and baby consumer Press.

The three-month campaign starts this month and includes two colour advertisements: one featuring the nurser and another featuring the Melamine plate, bowl and mug. *Cannon Babysafe Ltd, Lower Road, Glemsford, Suffolk.*

Ace addition

An athletic supporter (£4.55) has been added to the Ace Sport Range. *Harley Street Supplies Ltd, 26 Paddington Street, London W1M 3RF.*

Info service set up by Karvol

A Karvol information service has been formed to provide simple information for the public on the prevention and management of mild to moderate breathing difficulties, and particularly for the parents of young children who are

Scottish pharmacist Brian Eggleston, MPS (right), receives the colour television he won in a July Unichem/Sudocrem lucky draw. The presentation by Unichem director Theo Johnson was made at Mr Eggleston's shop in Cowdenbeath, Firth



frequent sufferers from this condition.

In consultation with the medical profession and health visitors, the new service has produced the first in a series of health education aids in the form of a poster entitled "Your child has a cold." A copy will be mailed to all health visitors in the Autumn for use in ante-natal clinics or, on request, for distributing directly to young mothers. The poster will also be available free on receipt of a 17p stamp, to readers of women's magazines. *Crookes Products Ltd, PO Box 94, 1 Thane Road, West, Nottingham NG2 3AA.*

Kodak change film numbering

Kodak have introduced changes to frame edge numbers on 120 and 220 Kodak roll films. Recognising the limitations of the 1 to 12 and 1 to 24 numbering systems when numbers occur on the join between frames the 120 size will now be numbered 1 to 19 at 4cm (1.6in) intervals and the 220 size will be numbered 1 to 40 at 4cm (1.6in) intervals. *Kodak Ltd, PO Box 66, Kodak House, Station Road, Hemel Hempstead, Herts.*

Simple on TV-am

Simple cold cream is being supported for three months by a national advertising campaign on TV-am. The new 10 second commercial, which is in addition to the existing £1m media activity, is being shown on TV-am from now until mid-December. *Albion Soap Co Ltd, 113 Station Road, Hampton, Middx.*

ON TV NEXT WEEK

Ln London	WW Wales & West	We Westward
M Midlands	So South	B Border
Lc Lancs	NE North-east	G Grampian
Y Yorkshire	A Anglia	E Eireann
Sc Scotland	U Ulster	CI Channel Is
Bt Breakfast Television		C4 Channel 4

Askit powders:	So
Bisodol indigestion remedy:	M, Sc, U
Cidal soap:	Bt, C4
Crookes One-a-Day:	All areas
Elastoplast:	All areas
Mafu:	Bt (Ln, So)
Milton:	All areas
Moncler Derma:	All except U
Oil of Ulay:	All areas
Philishave:	All areas
Pond's creams:	Bt
Sanatogen:	Bt
Simple soap & skincare:	Ln, M, A, C4, Bt

Chemist & Druggist 22 September 1984

Weigh up the advantages of New

INABRINTM

TABLETS



- A fast-acting and powerful analgesic containing 200mg ibuprofen B.P.
- Controls pain – Reduces inflammation
- High P.O.R. – guaranteed
- High standards of production by Upjohn – guaranteed
- High bonuses on attractive introductory bonus offer
- Highly responsible attitude to consumer advertising directing the customer to the pharmacist for advice



It will pay you
to recommend
INABRINTM
TABLETS

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launch deals, please contact
the SOLE DISTRIBUTOR:

PHARMAGEN LTD.

West Lane, Runcorn, Cheshire WA7 2PE

Tel: Runcorn (0928) 712918

Upjohn

UPJOHN LIMITED. CRAWLEY. W. SUSSEX

P.L. No. 0032/0710

Trademark: INABRIN

Packs of 10 or 20 Tablets
R.S.P. 79p. – £1.46 (including V.A.T.)

2450 L

Mentholatum CHEMIST



Our Autumn Double Bonus Plan for Fitter Business.

1

Profit from the Autumn Bonus.

Generous 12 as 11 or 12 as 10 bonus offers are available across the entire Mentholatum range – Deep Heat, Balm, Snug, Stop & Grow, Cutipen and Evenflo Breast Feeding Range. The bonus period lasts until October 31st 1984.

2

Cash in on the Deep Heat Double Bonus.

Double bonus offer on Deep Heat. Double bonus Cash Refund 12 as 10.

3

Take advantage of national TV advertising.

1983's Midland television campaign doubled sales in the area. (Independent retail audit). Now the same campaign is going national from October 15th.

4

Go for a holiday.

Win a holiday on us in Mentholatum's Free Prize Draw. £750 worth of "holiday-as-you-please" Thomas Cook Gift Vouchers to be won. Plus 10 Thomas Cook Holiday Vouchers worth £100 each.

Fill in the order card in the Mentholatum Autumn Mailing to benefit from the Double Bonus terms. Mentholatum Company Limited, Longfield Road, Twyford, Berkshire RG10 9AT.



The staff at Clapton Pharmacy, Upper Clapton Road, London E5 are the winners of Unichem's July Golden Dozen assistants draw. Receiving a cheque for £250 are (left), manager David Rosen, MPS, and assistants Mark Spring, Elsie Ward and Helen Hayes. Unichem's Walthamstow branch manager David Goulding is on the right

Organon launch one reagent kit

A new, advanced, one reagent, pregnancy testing kit is available from Organon Teknika. Neo-planotest Duocon (£30 plus VAT for a 30 test kit) is said to be a highly sensitive latex slide test developed using monoclonal antibody technology.

The test, which can detect pregnancy as early as four days after the missed period, uses two different antibodies sensitive to determinants on human chorionic gonadotrophin and is insensitive to relatively high levels of luteinising hormone reducing the possibility of false-positive and false-negative results.

The antibodies are attached to the latex and agglutination occurs when hCG is present ie when pregnancy has occurred. The test result related to the appearance of the slide is therefore the opposite to that obtained with the company's Pregnosticon Planotest, which is still available.



Bradosol's new image

Bradosol lozenges have been repackaged and now come in grey and red livery reflecting the brand's ethical heritage say Ciba Consumer Pharmaceuticals, Wimblesbury Road, Horsham, West Sussex RH12 4AB.

Larkhall symbols

Larkhall Laboratories are using symbols on their Cantassium products to "help buyers see at a glance which products are suitable for their particular diet needs."

The ten symbols, each comprising a pictogram and written title, indicate whether the vitamins, minerals or diet foods are "low sodium," "milk free," "grain free," "artificial additives free," etc. Distributed by Dendron Ltd, 94 Rickmansworth Road, Watford, Herts WD1 7JJ.

PRESCRIPTION SPECIALITIES

Kerlone tabs

Manufacturer Lorex Pharmaceuticals Ltd, PO Box 53, Lane End Road, High Wycombe, Bucks HP12 4HL

Description White, biconvex, film-coated tablets engraved "KE20" on one side with breakline on reverse. Each tablet contains betaxolol hydrochloride 20mg

Further information Betaxolol is a beta-adrenoceptor blocking agent which is cardioselective acting on beta₁ adrenergic receptors in the heart. It has a prolonged activity permitting once a day dosing. Its principle effects are to lower heart rate, especially on exercise, and to reduce systolic and diastolic blood pressure in hypertensive subjects. It has high lipid solubility which may facilitate rapid arrival at receptors but it is claimed not to cause more side effects. Absorption from the gastrointestinal tract is complete and not affected by food. There is little first pass extraction by the liver

Indications Management of hypertension
Dosage Adults: Usually one tablet daily. May be increased to two tablets daily.

Elderly and those with a history of bronchospasm: Starting dose of half tablet daily. **For those with renal or hepatic insufficiency:** Clinical surveillance recommended at start of therapy. Most of

the reduction in blood pressure is seen in the first three hours after the first dose. If the response is inadequate an additional antihypertensive may be used such as a diuretic. Patients can be transferred to Kerlone from other antihypertensives except clonidine

Contraindications Cardiogenic shock, uncontrolled congestive heart failure, second or third degree AV block if no pacemaker present and in patients with marked bradycardia (less than 50 beats per minute)

Warnings Concomitant administration with a myocardial depressant or inhibitor of AV conduction such as calcium antagonists of the verapamil type should be closely supervised

Precautions Care should be exercised when therapy is withdrawn. Patients with a history of cardiac failure, cardiomyopathy or cardiomegaly should be monitored carefully as sympathetic stimulation may be essential to their circulatory function. Use with caution in patients with broncho-obstructive disorders such as chronic bronchitis, with bronchospasm and asthma. And where PR conduction interval prolonged. In normal subjects Kerlone does not inhibit recovery from insulin-induced hypoglycaemia or mask the cardiovascular response. It is unlikely to interfere with glucose metabolism in insulin, treated diabetes but caution is

advised when treating such patients. Safety in pregnancy not established. It crosses the placenta and is excreted in breast milk. Side effects include lassitude at start of treatment, exacerbation of Raynaud's disease or intermittent claudication and paraesthesia of extremities. Possible side effects include marked bradycardia, hypotension, AV block, cardiac insufficiency and bronchospasm. Should be discontinued if rashes and dry eyes occur

Packs 28 tablets (£7.70 basic NHS)

Supply restrictions Prescription only
Issued September 1984.

Juvela lines on FP10

Juvela low protein loaf and dp low protein butterscotch flavoured chip cookies (£170g, £2.57 trade) have been accepted by the Advisory Committee on Borderline Substances and are available of FP10 prescription. The butterscotch flavour cookies are a line extension complementing the company's chocolate flavour chip cookies. G F Dietary Supplies Ltd, Lowther Road, Stanmore, Middlesex HA7 1EL.

PSGB labeller?

A certain computer labeller is being advertised as "the choice of the Pharmaceutical Society of Great Britain," both in the Press and publicly at exhibitions. What is surprising is this seemingly unannounced recommendation by a professional body, which in the past has been steadfast in its desire to remain unbiased, and determined to show no favour to any system.

It is also surprising that a sudden recommendation has apparently been made without any truly representative appraisal of the systems on the market, many of which are well advanced in terms of sales and experience, and which use tried and tested equipment of worldwide renown.

Perhaps the advertising is misleading and in fact refers, not to the Society's choice of system, but to their choice in awarding a grant to "develop a system." If so, surely, it is in the interests of all members that this situation be clarified by the Society's denial of any specific recommendation and by their preventing further misleading advertising.

Alternatively, the Society should conduct a fair and proper appraisal of all systems on the market, as was carried out, and is constantly being reviewed, by the National Pharmaceutical Association. Only then can a recommendation be regarded as being worthwhile, and would surely indicate only those systems which gain their position and reputation on merit, performance and through widespread use and recommendation throughout the whole of our profession.

John Richardson.

John Richardson Computers Ltd,
Preston, Lancs.

Good relations

Comments in this week's pharmaceutical Press, including those from our president, seem unlikely to foster harmony between pharmacist and doctor.

Each profession sees the other as poaching. The medical man or woman becomes increasingly interested in dispensing, while the pharmacist is more and more encouraged to explore fields hitherto regarded as outside the pharmaceutical function. Rivalry rather than collaboration appears to be the trend.

Because of my concern, I recommended, in my submission to the Nuffield Inquiry that the professions of pharmacy and medicine in the *general practice* sector be combined.

At the end of (say) ten or twenty years there should, I suggest, be a single combined qualification to practice as community pharmacist and general practitioner doctor. The schools of pharmacy and medicine should begin at once to discuss the steps needed in adjusting training and entrance requirements.

The foregoing is only one of the proposals I have made and I am confident it will meet much opposition. There are threats to vested interests: I also recognise that many will object from the purest of convictions.

The time has perhaps come to reverse the events of over a hundred years ago, to look to integration rather than separation. Could we try to put the interests of the public ahead of any sectional advantage?

Allow me to emphasise that the merger I suggest is for general practice pharmacy and general practice medicine only. And for those prepared to suffer the impact of my full submission to Nuffield I shall be happy to send a copy on receipt of a stamped addressed envelope, size A5. (6 Attree Drive, Queen's Park, Brighton).

E.A. Jensen.
Brighton.

Rural set-to

In *Doctor*, September 6, there is a front page heading "Rural doctors to fight chemists."

It seems pharmacists are threatening the livelihood of rural doctors. Not because pharmacists are taking on the job of doctors, but simply because pharmacists wish to provide a proper pharmaceutical service to rural patients. The article states that in spite of the fact that pharmacists are working within formal guidelines the dispensing doctors have had enough. "It is time," says Dr Richard Jones, "for GPs to do something about pharmacists niggling and nit picking. And Dr Kenneth Rooke complains that pharmacists are conducting a national campaign to gain monopoly over drug dispensing."

It would appear that at last pharmacists are pulling together in an effort to widen pharmaceutical services to the rural patient. The RPA is delighted to see evidence of such action and can only hope that Dr Rooke's fears are well founded.

The speech of the president of the Pharmaceutical Society to Conference could not have been more appropriate and timely. Though I think that there can be few pharmacists who bow the knee to their doctor colleagues these days — it is far more likely that the necks are cricked looking at those on pedestals. However, Dr

Maddock's address was perhaps the most robust and honest one for many a year, and the RPA hopes that members throughout our profession will appreciate the candour expressed and the courage of the speaker.

It is hoped this new era of candour will effectively create a unifying influence on our profession and at the same time show rural doctors that rural pharmacists mean business.

However, I don't know how many rural pharmacists Mr John Patten has spoken to, or for that matter how many doctors' surgeries he has visited, but if he thinks that the rural dispensing problem is an irritant of a minor nature, he must be living in some dream world.

At a time when doctors are voicing their opinions about making dispensing a free for all, when doctors are claiming rights which would kill off many a pharmacy should they get their way, John Patten calls such actions as minor irritations. He sadly misjudges the feelings of rural pharmacists if he thinks that we will accept that so called doctor dispensing is an adequate substitute for a professionally run pharmaceutical service.

May I invite him to call on some RPA members — in Norfolk, Kent, Cornwall and Gloucester. He would get a true reflection of what he cares to call a "minor irritation."

John Davies.

Secretary,
Rural Pharmacists Association.

Symbolic for pharmacy?

It is to be hoped that your readers will not be influenced by the remarks of "Xrayser" (*C&D* September 8) as to his "absolute right to use a correct facsimile on my premises, irrespective of who made it."

The symbol is the copyright of the Society, whose permission is required before it may be reproduced. As has been made clear, GEC Claudgen Ltd are the only company at present licensed to reproduce the symbol, for permanent sign.

The Boots company asked for, and were granted, the Society's permission to reproduce the temporary sign on cards to replace the stickers.

The policy that is being pursued by the Society is necessary to protect the integrity of the symbol and is, therefore, in the best long term interests of its members.

Philip Paul.

Director of public relations,
Pharmaceutical Society.



Keep the till ringing with Meloids.

There's always been a widespread and almost fanatically devoted following behind these excellent little liquorice and menthol lozenges in a tin.

They really are the answer to huskiness or a ticklish throat.

Combine this strong brand loyalty

with a high profit margin and you're on to another winner from Crookes.

Remember too, that Meloids support the National Annual Town Crier Championship. Place your order now and you'll have plenty to shout about when the till sounds Melodious!

We
promised
you the
greatest
exposure
ever.

And look what developed.

A summer campaign to outshine everything that'd gone before.

Award winning commercials for 'Kodak' Film on nationwide TV. The brilliant Peter Bowles "Shower" commercial for Disc cameras.

Memorable and powerful campaigns in the Sunday magazines and TV Times for 'Kodachrome' Slide Film and the 'Kodacolor VR' Film range.

The full colour, double page, "professional endorsement" campaign using world famous photographers like Lichfield and Bailey.

Dramatic interpretation on 'Kodak' Film of the great works of Old Masters in specialist photo press.

All this backed with a powerful range of sensational promotions, including beach balls, free films, free film pods and, of course, the spectacularly successful Disc Exchange. Each promotion supported by comprehensive p.o.s. Not forgetting the superb range of stock boxes - designed especially for you.

All in all, the most impressive picture Kodak has ever developed.

Keep it with Kodak.

Kodak, Kodachrome and Kodacolor VR are trade marks.



The dos and the don'ts

Pharmaceutical experience of electronic point-of-sale from three very different points of view – the single proprietor, the small multiple, and Boots – was presented to a special pharmacy session of EPoS 84 on Wednesday. In the first paper, Roger King, who until recently ran his own pharmacy in Hedon, Hull, but is now a computer consultant, sets out EPoS guidelines for the newcomer.

ep
08/84

Over the ten years I have been involved with EPoS, from a bureau-based system to stand alone, I have learned a few lessons both from my own experience and from colleagues. So what exactly should one expect from a system in a community pharmacy?

Electronic point-of-sale terminals are capable of capturing and recording data on every item sold using a product code. This code should be at the discretion of the user and may or may not be PIP code. Having personally set up coding systems, both structured and unstructured, ranging from four to seven digits, I can state with authority that there is only one disadvantage of using PIP at point-of-sale: in spite of it now being quoted as two blocks of three digits, manual entry of six digits for each sale is a bit cumbersome.

However, there are ways to circumvent this problem and the big advantage of using PIP has to be that the code is maintained for you and published by *Chemist & Druggist*. Even more efficient, if one uses the system described by Anthony Payne, it is possible to have file updates supplied on disc by Fairscan, the company responsible for maintaining the NPA's master files.

Whether or not one uses PIP code internally is irrelevant when it comes to ordering, as any system worth having will give you a supplier code file. This means that if you want to give all your business to Unichem you can still use PIP internally provided you set up Unichem's product file under supplier code. However, if you use PIP externally you can talk to Vestric, Macarthy's, or any other Numark wholesaler, and an increasing number of independents who are still vital to

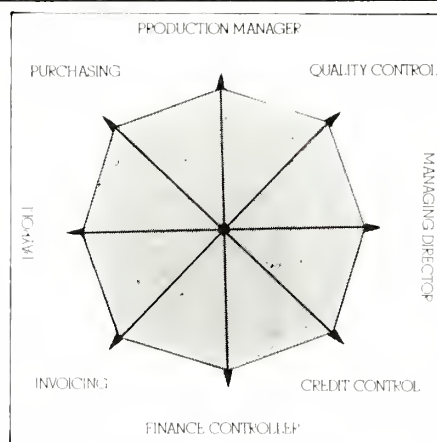


Figure 1

the distribution network.

To return to manual keying, there are two methods of short circuiting the operation. These are price look-up (PLU) and bar coding. PLU means that by entering a user-defined code of one, two or three digits, the sale of the product is recorded under its full product code and the price appears on the cash register display.

Bar coding is a wholly different concept. Most people will be familiar with the series of bars of various thickness used to depict the 13-digit EAN code. The numbers are also printed in case you want to key them in by hand! It is a sad reflection on our situation, however, that products sold in pharmacies which carry bar codes do so because of the "muscle" of the supermarket giants.

Pharmacy does have own problems, however. Transfer bar codes to items as small as an eyebrow pencil or as soft as a bag of cotton wool and the strike rate (the number of times that the code is read correctly first time) drops dramatically. Some years ago Vestric undertook a trial with three of their customers in the South East in conjunction with Chubb Cash and Scandata. They supplied terminals with light pens and Scandata's computer printed the bar code labels as required by the goods ordered. The trial was useful in that it showed all of us who were involved or observers, the wrong way to go about such a project. No sarcasm is intended as in those days we were all fumbling in the dark and this failure was just as useful as a success.

It is largely in the light of this trial that I make the above comments and although the quality of today's bar code readers is vastly superior to those used in the trial, I believe that they are still pertinent. I am sure that bar coding will come in for OTC products over the next few years, but not as quickly as some people would have us believe. The problems of applying bar codes to small products is easily overcome by blister packs or carding and soft packages could have a rigid label attached at the manufacturing site. However I do not think bar coding will make any impact on pharmacy until the cost of laser scanners comes within reach of the pharmacist.

There is one other aspect that advocates of scanning carefully ignore. It is that to be effective a scanning-based system needs total PLU facility across the entire inventory

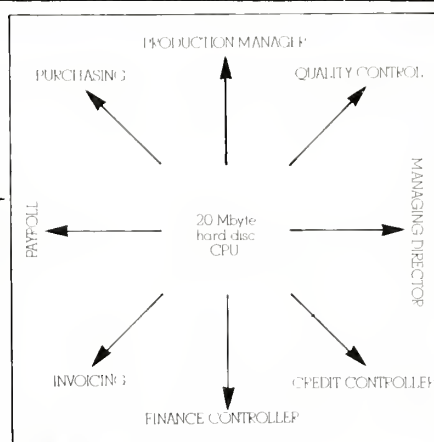


Figure 2

range. After all, what is the point of scanning the product code and then keying in the price? Omron, whose hardware I admire, can give you virtually limitless PLU facility but at a price. Over a certain number you need an external memory file (EMF), which is very expensive, even though it can be shared by several tills. The advantage of the EMF is that price changes need only to be done once for all the tills to give the correct prices.

The alternative to such a set up is to have the EPoS terminal hardwired on line to your computer and maintain the price file on this. If I could justify the cost, it is probably the solution I would favour provided it could be installed within the physical constraints of the pharmacy. Many micros are capable of being "networked", as are many so-called professional computers. This means several computers each doing their own thing can talk to each other if required, and use information on each other's files.

A typical network for a manufacturing concern could appear as in figure 1, using a variety of Apricots. The various stations are theoretical but each one represents a separate Apricot.

To get true multi-user functions, it is necessary to go up to something like the Equinox. In a multi-user system the computer acts as central processor and store for a number of terminals, each of which can access the same hard disc at the same time to draw off what information they need into their own memory. They can play with this data and shunt it back again. The set up for the same firm becomes as in figure 2.

To compare costs, the Equinox 20 megabyte computer is about 50 per cent more expensive than the 10 megabyte Apricot but the overall system becomes cheaper pro rata the more terminals that are added as an Equinox terminal is half the price of an Apricot.

If we transfer this concept to a pharmacy, we have the possibility of a total "in-house" package which would appear as in figure 3.

To put this in perspective, as the labeller would be on line, it would be possible to have a live patient medication record system running concurrently with PLU for the tills and a clerical assistant looking after accounts and payroll. If the LDS keyboard and screen were placed on the prescription counter and the printer in the dispensary, the pharmacist

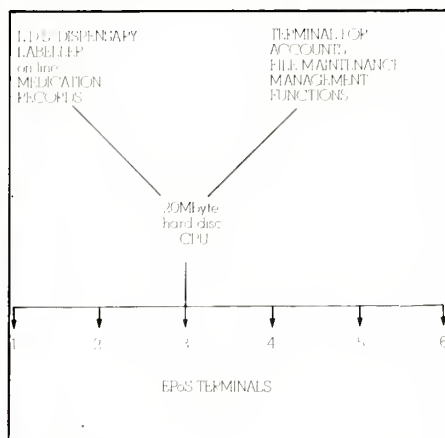


Figure 3

could enter prescriptions as received, interrogate the records and pass the dispensing operation to technicians. Such a system would be expensive to install and at present could be justified only in a large pharmacy.

For the medium-sized pharmacy however it would be possible to produce a networked system on an Apricot or similar but it would not be possible to have a live PLU file on line to the tills. Do as much routine processing as possible overnight to avoid delays during daily running.

In conclusion I consider EPoS made a valuable contribution to the profitability and smooth running of my pharmacy and that faced with a similar situation today I would do it all again. I have put together a few basic facts which should not be overlooked before contemplating installation of any computer system.

Remember:

Computers are not infallible: Problems with mains voltage, thunderstorms, hardware faults, etc, can make nonsense out of the best software.

Computers are less fallible than humans: Most so-called computer errors are due to faulty programming or operation.

Computers cannot think for themselves: They are incapable of adjusting for operator errors such as spelling mistakes.

A computer is like fire — a good servant but a bad master: Never allow a system to become too heavy or it will create more work than it saves.

DON'T expect to install a computer system on Monday morning and for it to be running your business for you by the weekend.

DO choose the slackest time of year to install a system.

DON'T try to get a sophisticated system up and running in one go. If it's any good it can be implemented in stages.

DO decide exactly what functions of your business you want to computerise and in what order.

DON'T be conned into believing that a tape load system on a home computer can run a reasonable-sized business.

DO consider your staff. They may well be apprehensive about computerisation. Emphasise that you will be learning with them. DON'T forget yourself. Somebody must be capable of day-to-day running of the system in your absence or you will never get a holiday.

DO shop around before you buy. Check on the credentials of suppliers and satisfy yourself that they are likely to be in business in five years time.

DON'T be a guinea pig unless: (a) you are really enthusiastic about computing. (b) you are adequately subsidised for the job. (c) there is no other way out.

DO check up on reference installations. Make sure that other users are satisfied with the system.

DON'T buy software that has been modified by anybody other than the original author.

DO make sure that a package exactly suits your needs. Modification may be expensive. DON'T modify your business procedures to fit the system unless the modification is an improvement in itself.

DO consult your accountant before computerising your accounts. There are packages on the market which actually take more time than a good manual system and you will save nothing in audit fees.

AND FINALLY: If you can justify the cost *do computerise*. Although sometimes frustrating, it can be a most rewarding exercise.

A group gets it together

Experience of EPoS in a five-pharmacy group is here presented by Anthony Paine, managing director of Westlake Chemists, Oxford.

ep
os

Outline history

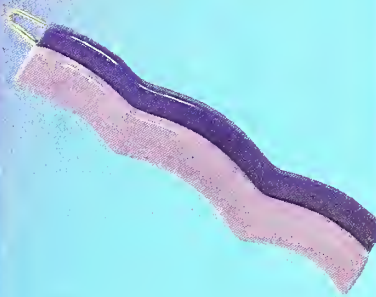
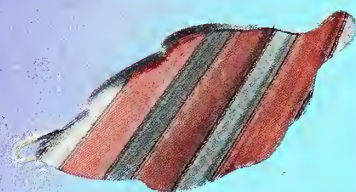
This is a case study of the entry of a small retail pharmacy multiple into electronic point-of-sale, and of its attempts to make EPoS pay.

Entry resulted from a conviction that some of the company's problems could best be solved by an EPoS system capable of being developed into other data processing areas. Contacts between Westlakes and potential suppliers date from 1980, but firm progress was not made until mid-1981 when the first of the company's branches was put onto the Positive system supplied by Allen Computers, through Independent Retail Computer Systems as agents. Development and further implementation of this system continued until July 1983 and inclusion of the company's fifth and final branch.

Following doubts about the system's

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financial viability, a detailed cost/benefit analysis showed that in Westlakes' case, the system chosen was not cost effective and was not likely to become so in the foreseeable future. The company therefore withdrew.

However, a replacement system was clearly needed so the company used the notice period to refine its requirements and then canvassed over 100 potential suppliers of manual and computer-based stock control systems. Eventually, the decision was made to stay with EPoS and to use the "stock manager/PoS manager" packages from Channel Business Systems, sold into the pharmacy by Fairsan.

Now, four months after the theoretical transition between systems, the change-over phase is nearly complete, involving initial file establishment, parameter setting, and then the processing of a backlog of daily transaction data. The next stage involves file editing and error correction.

Reasons for EPoS

EPoS was originally thought to be a good idea — in the absence of a more exact judgment — because the company had grown by acquisition and had branches being run as more or less independent units under central control that was recognised as being too loose.

This leaning towards EPoS was reinforced by the fact that problems were seen to be more serious on the over-the-counter side — the side EPoS controlled — than they were on the professional side where there was no compelling reason to introduce expensive control systems.

It was realised that there were serious deficiencies in almost all aspects of the company's retailing when these were compared to the best of the multiples: ie range selection, buying, stock control, merchandising, promotions, financial control, and performance measurement. It was also recognised that attention had to be paid to areas other than PoS (for example training, company image, and branch refitting) but that the prime requirement was for good information of the sort only PoS could provide.

Specification and strategy

In the early days of implementation, both Westlakes and the system's suppliers had to concentrate on short-term problems to get the system up and running as soon as possible, and then on small enhancements to improve efficiency. Westlakes were regularly asked for feedback by the systems house and gave it. However, there was not enough certainty over what would eventually be needed because the company did not know.

Reasons for this were as follows: First, it was not clear in advance how the detailed operations of our chosen system would work in practice; second, we had no idea which

bright ideas would remain as such and which would be cost-effective enough to incorporate; third, there was no industry track record to follow; and fourth, it was finally realised that the company had no clear long-term plan, ie a goal with firm ideas on how to reach it.

Company plans obviously had to be defined before the required system could be specified, and in doing this, the following questions had to be answered:

- (a) Time scale: Since the objective was to define requirements for a computer system, the likely life of the system had to be estimated so that planning could be focussed on that period.
- (b) Growth: This had to be estimated, to be certain that the chosen system could cope.
- (c) Detailed management strategies: Decisions had to be taken on how the company expected to tackle problems in the various aspects of retailing listed above.

In Westlakes' case, most of the open questions centred round the balance of centralisation/decentralisation of warehousing, buying, etc envisaged and answers followed from the pivotal decision to reduce central operations to the absolute minimum that allowed acceptable efficiency. Branches were therefore to be treated as buying/stock-holding centres in their own right.

Raised efficiency and improved control was expected to follow from the provision of good information and training on how to use it, and from good communications to cement a team approach to management.

Product coding

In 1980, when exploratory feelers were first put out to EPoS, there was little choice of system, it was not clear if there were to be industry standard product codes, and it was not clear whether hardware and software — often with roots in the American market — could be applied to small UK pharmacies.

Although Westlakes obviously had the choice of whether to go into EPoS or not, it transpired that this was the only effective choice that it had. This followed realisation that the only possible system to use was the one where there were product codes already.

To explain: the proper operation of any system depends totally on unambiguous and accurate coding, and this in turn depends on the establishment and maintenance of a coding master file. In the pharmacy sector, there are only three choices: (a) to establish and maintain one's own; (b) to use an industry standard; (c) to use a wholesaler's system.

It was decided that (a) was too time consuming, that (c) was unacceptable because it compromised the company's independence, which left (b) the industry standard — and that meant PIP codes.



Omron Systems 80 cash register

Because this coding system was not available on any other EPoS system at the time, PIP determined Westlakes' choice of EPoS supplier.

PIP coding — Pharmaceutical Interface Product Coding — followed impetus within the National Pharmaceutical Association/Independent Chemists Marketing Ltd. It was seen that there was no hope of computing for the small independent pharmacist unless there was a coding standard, and indeed that the whole pharmaceutical distribution industry might be hampered because all the large organisations had coding systems that were incompatible.

The PIP code itself is a simple unstructured six-digit numeric code with a check digit. The coding system has limitations but was merely specified to fill a gap until EAN codes become universally applied to the sector — or nearly so. When they are, this will provide another choice.

In Westlakes' experience, apart from some very minor details, PIP coding works well.

Most other factors influencing the first decision to enter EPoS were more predictable, eg projected costs/benefits, and belief in suppliers' promises on performance and support.

However, attention should be drawn to the significant alterations to work practices that the introduction of an EPoS system requires. The company had to decide whether it should or indeed could alter ways of working to fit in with these constraints.

Operation

Most point-of-sale systems suitable for retail pharmacy would have to work in essentially the same way — and indeed, there are more features common to both systems that Westlakes have used than differences.

With both old and new, branch hardware and all branch operations are the same, except those to do with the different method of data transfer — via telephone or, as now, physical transfer of tapes. Product labelling is still done manually with hand held guns — goods being marked with code and price, price look-up not being used; codes are still found from our own PIP directories, the

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C&D Price List and when replenishment reports again arrive, from them; entry is still by keyboard — bar coding and scanning/wandering not being used. Also, nearly all input to the EPoS system is done through branch PoS terminals; only certain editing and senior management functions have to be by VDU.

There are obviously many detailed differences between the two software packages. However, they both do the same job of keeping running records of all lines stocked at all locations and amending these according to input from transactions at the terminals, ie sales, stock receipts, etc. Suggested stock orders and various management reports are then produced.

End requirements

The company had to be clear about what was wanted from the system, not in terms of day-to-day information, but the overall effect to be produced. Sometimes it was easy to lose sight of this.

The system is expected to:

- (1) Reduce capital tied up in stock by increasing stock-turn, doing this through improved stock control.
- (2) Increase sales by improving day-to-day buying and stock control, and by giving the information by which senior management can improve range selection, merchandising, and promotions.
- (3) Improve profit margins by enabling the company to better use its buying power.

There were also "soft" benefits, but there were not easily quantifiable, the above were the "hard" benefits taken into the cost/benefit analysis. At the corporate accounting level, EPoS had to be seen simply as a tool to achieve these ends.

Costs

Against the above forecasts of benefits, the company has to set actual and forecast costs. Included here were the following:

- (1) Depreciation and interest on capital equipment — originally just on PoS terminals and labelling equipment, but now also on computing equipment.
- (2) Maintenance charges — on the above.
- (3) Bureau charges and/or after sales support and/or information services — eg access to product coding.
- (4) Insurance.
- (5) Communications costs.
- (6) Consumables.
- (7) Marginal staffing costs — above the level of the earlier manual system.

Westlakes' cost/benefit analysis on the first system showed a large excess of costs over benefits. With the new system, cost cutting and clearer ideas on how to achieve benefits are expected to bring this to breakeven for 1985. Theoretically therefore, Westlakes is still in EPoS on the expectation

of hard benefits beyond 1985 and soft benefits before.

During the life of the current system, the company sees three main areas for system development in addition to the normal process of software maintenance and enhancement.

The first concerns the tasking of the computer. Although a multi-user/multi-tasking system, the machine is now being used only on the EPoS packages. It will be developed to handle most office functions including integrated accounts, payroll, personnel records, word processing, financial modelling and management reporting and perhaps internal mail if branches are given terminals as described below.

Secondly, since the company's policy is to co-ordinate, control and improve branch buyers rather than to centralise this function, they will want direct access to the system to get their own reports on demand. This will require communications facilities and hardware in the branches that can be used as terminals.

Thirdly, the coming of EAN coding will mean that the company is likely to change over to this at some stage. It will entail software alterations, hardware additions to incorporate scanning, and alterations to staff working practices.

Implications for personnel

The introduction of EPoS caused more problems in this area than expected.

In the event, working practices had to be substantially altered for branch staff, far greater demands for discipline and care were made, new senior jobs were created, and staff attitudes at all levels often had to be turned round — so far as is possible.

Conclusions

In retrospect, the writer's opinion on EPoS is that Westlakes were right to go into it.

This view is held *despite* the fact that it would have been a lot more comfortable not to have been a pioneer, *despite* the money that has been lost so far, and *despite* delays, setbacks and outright mistakes. Also, it will never be known what opportunities elsewhere have been missed as a result of the money, time and effort spent on EPoS.

However, the company is not unusual in wishing to become more profitable and to expand. The only way this will be achieved is by concentrating attention on retailing activities so that these are done better and that capital tied up in stock can be liberated. The most radical way of tackling this is to introduce EPoS and work outwards.

It has to be borne in mind that the whole area of retail sales accounts for only half the company's business, and that attention here is given limited time and resources while the work of the dispensaries is maintained to the

highest possible standards.

The company recognises the importance of the professional side of its operations, while also recognising that it is unlikely to give significant growth or improved financial results. Hopes for these rest with EPoS.

Boots go scanning

Boots are now making their big thrust into EPoS, according to Mr Caird Biggar, head of management services.



The company has over 1,000 branches, ranging in size from 2,000 sq ft pharmacies to 45,000 sq ft department stores, and over 50,000 products in the largest branches.

In 1976-79 a PoS trial was run in one large branch, with 60 tills and using magnetic labels, plus a trial in one small branch with four tills and bar codes. Over 30,000 items were on full price look-up; the equipment was Sweda, with Duplex computers. Point-of-receipt was also tried. These trials were discontinued in 1979, the principal reasons being (i) all PoS equipment was too expensive at that time, and (ii) it was too costly to stick on the labels.

Automatic stock replenishment is already in operation on a high proportion of lines, based on stock counting, and the information gathered is now being used more systematically to build formal sales and stock database. On-line access to this database is being provided to buyers and distributors. However, stock counting is only an interim stage before full PoS — which now looks to be an economic proposition because of EAN and cheaper PoS equipment.

For the future, the first essential step is to get the maximum number of lines bar-coded at source with EAN. Over 4,000 Boots suppliers have now been requested to print EAN bar codes on their products by mid-1986 and meanwhile Boots are pressing on with own manufactured lines and own brands. Already 20 per cent of items going through the tills are bar coded, and 50 per cent will be reached with own manufacture and own brands. A total of 90 per cent or more should be reached with proprietary lines.

New PoS trials in two or three branches are being planned for 1985 and 1986, with equipment from various suppliers being studied. Duplex configurations will be required with full price look-up and wandering of bar codes. If the trial is successful, national implementation may start in 1987.



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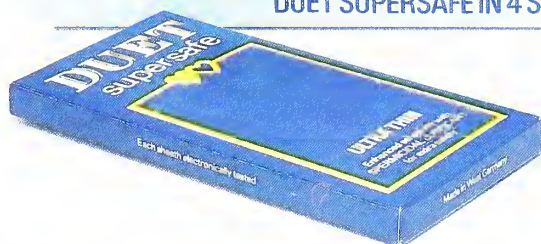
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Ways to better health care in pharmacy

The health centre concept was brilliant but has failed to live up to expectations, claimed Mr William Beanland, superintendent pharmacist and managing director, Rawtenstall health centre pharmacy, during Thursday morning's professional session.

Most health centre districts had developed so that there were a number of under-employed pharmacists in their original pharmacies, plus one who was grossly overworked (and underpaid?) who could not possibly fulfil his role, no matter how dedicated he might be.

"There is a real danger," he said, "that we are creating a series of factory-pharmacies whose only concern is to churn out dispensed medicines in the shortest possible time; where speed is the criterion of efficiency; where sympathy, understanding and care cease to have meaning."

He knew of health centre pharmacies dispensing up to 16,000 items a month with only one pharmacist. The pressures were tremendous and the pace killing. In his paper Mr Beanland proposed a plan for establishing consortia that would reduce some of these pressures and enable pharmacists to develop their role in health centres. The following is an extract:

The greatest opportunities for health centre pharmacists exist in helping prescribers and ancillary services with direct access to doctors and receptionists, nurses and clinics, queries can be resolved speedily without the patient being aware that they exist. Being under one roof makes personal contact easy and, if the pharmacist is prepared to work at it, a satisfactory and rewarding relationship can be built, resulting in a health care role which, though unobtrusive and largely unrecognised by patients, is probably the most effective of all the therapeutic roles.

This relationship is further enhanced by a deeper understanding of the problems of the "other side", and a realisation that prescribers also have their difficulties, not least of which is dealing with requests for repeat prescriptions and treatment based upon the patient's own diagnosis. I have yet to see a satisfactory system, apart from a computer, capable of dealing with these latter, and the involvement of the pharmacist could be of enormous benefit.

In spite of the benefits of close contact, the therapeutic role of the health centre pharmacist is by no means fully exploited. The main reason why there is little or no counselling, is the sheer volume of work which makes it impossible to devote time without seriously interrupting the flow of prescriptions. There is an obvious shortage of qualified staff due, in part, to the continuing refusal of the NHS to pay additional pharmacist allowances. The inadequacy of the premises (and this applies even more in traditional pharmacies), with no private room for confidential discussions, deters people from requesting advice.

There are many opportunities for the community pharmacist to make fuller use of his knowledge and expertise, for example, in educating the lay public in health matters, taking a weight off the doctor's shoulders by testing urine and blood and monitoring blood-pressure, etc. There is scope for developing a domiciliary service for the old and infirm, and holding teach-ins, particularly to young people, on subjects such as drug misuse and contraception.

Sadly, these possibilities are little more than pipe dreams. Firstly, they would cost money, and the Government has stated categorically that it will not even consider individual costings. Pharmacists themselves are unwilling or unable to pay for the larger, improved premises and additional staff required.

Most health centre pharmacies are owned by a consortium of pharmacists and pharmacy owners, all of whom are directors and shareholders because they were in practice locally when the centre was proposed. The shareholders are usually independents with one, possibly more, company chemist. Pharmacists die: companies do not. In 20 years time the health centre pharmacies could end up as branches of the company chemists. Pharmacy's official bodies originally co-operated in drawing up model rules for establishing consortia pharmacies; they got it wrong and it is now time for them to get it right.

The ideal way to establish a consortium is for all the pharmacists whose businesses are affected to combine into a group or company, each putting his business(es) into the group and becoming an employed director. The group would then establish the new pharmacy in the centre, close



Mr William Beanland

some of the existing businesses, possibly resite others and continue to operate the remainder. The needs of the whole district would be covered from the main (health centre) pharmacy and the minimum number of satellites. This would allow free movement of the pharmacists in the group, possibly on permanent rotation, with more than one working in the centre, and with adequate cover for sickness and holidays. In this way a better and fully comprehensive service could be provided to the community, with better conditions and probably higher incomes for the pharmacists, and a show-case pharmacy to set high standards. As pharmacists left the group they could be replaced by simple appointment.

Until this happens, however, steps must be taken to ensure adequate qualified staff in the health centre pharmacy. Only in this way will opportunities be fulfilled. The opportunities are there, but they must be worked for: they will not be given freely. The reward will be tremendous, and not only for pharmacy: the medical and ancillary professions, the community, and the NHS all stand to gain.

Pharmacists 'always there'

Advising on family health care should be the community pharmacist's main role in the 1980s, said Mrs Linda Stone, member of the Pharmaceutical Society's Council.

A community pharmacist herself, she said she had no intention of being "just a pill-pusher" or "the machine-operating implementer of an untrained receptionist's orders."

The traditional community pharmacy was ideally placed to fulfil an educative role and, with over six million visits made to pharmacies every day, it would not take long to educate the whole population in health care. Unlike other health care workers, pharmacists were "approachable" and "always there" to provide advice. They also came into contact with customers in good health as well as in bad health.

With the proliferation of doctors' appointment systems, accessibility to the public was becoming even more important and an adequate distribution of pharmacies was essential.

"They must be in places where the public require them, rather than being sited purely where we want them for profit," said Mrs Stone. "The general public likes a pharmacy next to a health centre or group practice for convenience, but it also needs one in the shopping area — whether suburban parade, a large city centre, out of town superstore, or a small rural village — for its general health care needs. It is the provision of these general health care needs which provides the direction in which we have an expanding role, caring for the community as a whole."

Mrs Stone was not convinced of the need for separate counselling areas: "We have to be very careful not to undermine the informality that is our strength."

She went on to suggest that the provision of a domiciliary and 24-hour on-call service would mean that "no-one could argue with our justified claim to be the ideally-suited profession to carry out this educative role in the community."

Some of the many areas in which pharmacists could become more involved included invalid aids, incontinence, infant feeding, pregnancy, family planning, general hygiene, diets, dental care and menstruation.

A GP's view

Dr B.W. McGuinness, Hallwood health centre, Runcorn, gave a general practitioner's views on how pharmacists could contribute to the primary health care team. He saw the pharmacist's role in three parts — educational, therapeutic and research — which could be developed in the following ways:

Pharmacists should take on a more active supervisory role, perhaps seeing patients once or twice daily by appointment to encourage compliance and monitor side effects.

They could be involved in the management and detection of hypertension by measuring blood pressure and they could give simple hearing checks to the elderly and children who have fluctuating deafness after repeated respiratory infection.

Pharmacists could take haemoglobin measurements before dispensing OTC iron preparations. "All modern physicians regard it as folly of the highest order for any haematinic to be dispensed in response to vague symptoms like tiredness, depression or poor appetite." Dr McGuinness believed the only indication

for oral iron was iron deficiency anaemia diagnosed specifically and treated only by a doctor, so that OTC iron preparations were a "dangerous anachronism".

Dr McGuinness also suggested that pharmacists should discourage widespread self-medication with "superfluous" vitamins.

Pharmacists could provide contraceptive advice in private and by appointment if necessary, particularly to help the young. "Just selling condoms over the counter is not good enough."

Pharmacists could make a huge contribution in educating the public through the media in the correct use of medicines. They could extend their role in nurse education to include midwives by advising on the use of home remedies, especially in pregnancy.

Hallwood health centre has a research pharmacist working closely with the other professionals. Together they have developed a "preferred drug" formulary and reduced drug costs by a quarter within two years.

Dr McGuinness suggested that, to put these ideas into practice the pharmacist might need to become less of a shopkeeper, more of a scientist, health educationalist and fully integrated member of the health care team. "If the opportunities are grasped and stronger links with other professions forged with conviction, tact and persistence, the professional rewards and satisfaction for the profession are immense and the potential benefits to our patients great indeed."

Throughout his talk, Dr McGuinness stressed that the accent should be on prevention and health education, otherwise the new diseases of modern society would lead to a "health crisis 2000." These new diseases had social origins and were particularly difficult to treat because they required changes in behaviour and lifestyles.

During the discussion, Dr T.G. Booth, vice-president, Pharmaceutical Society, pointed out that the main problem to be tackled now was how to remunerate

pharmacists for providing this service of health education and counselling.

This was likely to be one of the important areas the Nuffield Inquiry would be investigating.

When the speakers were asked what part pharmacists could play in combatting drug abuse, Dr McGuinness explained how he and his partners wrote under pseudonyms, short articles for local newspapers on various health problems, such as how to stop smoking, preventing heart disease and so on. Drug dependence might be a topic that could be covered in such a way.

Lecturing to schools and youth groups was more difficult, because the audience might be less than receptive, but at least pharmacists could make it clear that they were willing to offer such a service.

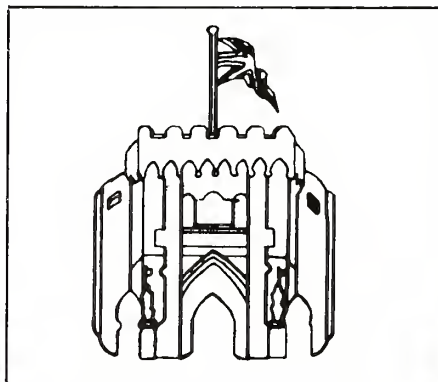
Mrs Stone believed that the abuse of prescription and OTC medicines was a separate issue from the abuse of "hard" and "soft" drugs, and to advise on the latter without the necessary specialist knowledge could be counterproductive. She did, however, think that pharmacists ought to be able to make some useful contribution in this area.

Part of the discussion centred on the need for communication skills. One member of the audience pointed out that customers sometimes resented being offered unsolicited advice, to which Mrs Stone agreed that one needed to be an amateur psychologist to know how far to go with an individual patient.

Dr McGuinness said that the public would only know what was possible in health care if they were told. For example, cervical screening had been available to women for several years but many were still reluctant to accept regular smears because they did not understand the significance. There was no point in writing scientific articles in upmarket newspapers because they were unlikely to reach the target audience. Whenever Dr McGuinness advised his patients about cervical screening or breast self-examination, he always handed out at least two leaflets and asked the woman to give one to a friend.

Another point Dr McGuinness made during the discussion was that Britain spent less of the gross national product on health care than any other industrialised nation, with the possible exception of Japan. The answer to how far the nation could go with preventive health lay to a large extent with the policymakers and the electorate.

Mrs Stone was convinced that the savings engendered by good health care and preventive medicine would more than pay for the costs, but funds were necessary to set these schemes in motion.



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Vaccine progress due to biotechnology

Enormous progress has been made in the last 30 years in the control of viral diseases by vaccines and "we are on the threshold of a new era combatting these using new technologies," Dr Geoffrey Schild of the National Institute of Biological Standards and Control told the Conference last week.

Viral disease continues to have a major impact and vaccines are still the most powerful tools for combatting viruses. There are antiviral drugs such as amantidine and acyclovir, but progress in this area has been slow, Dr Schild said. Passive immunoglobulins are also used but are of specialist value. Thus vaccines probably provide the most valuable treatment in terms of cost effectiveness. "For a few cents one can confer life-long

immunity." The World Health Organisation reckons that it costs US\$2.50 per head to immunise against six diseases, and further developments are emerging using the so called new technology or biotechnology to produce more effective and cheaper vaccines against a wider range of diseases (see also *C&D* July 14, p84). That does not mean to say that "crude vaccines" such as that for vaccinia (smallpox) or the measles vaccine were not effective. Smallpox has been "officially" eradicated worldwide. Measles vaccine has been extremely successful too, so it would not be necessary to replace it with a vaccine made using new technology, Dr Schild explained.

Conventional vaccines are one of two types: The first are inactivated (non-replicating) antigens where the virus is grown in cell culture, inactivated with an agent such as formalin and the resultant

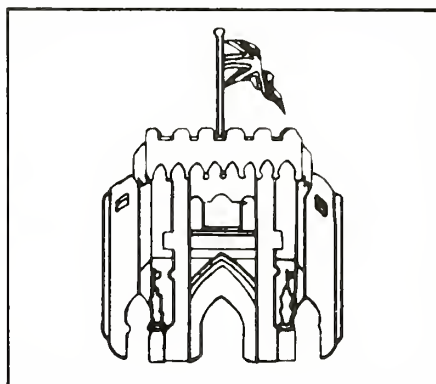
injected to evoke such an immune response. The second type — which are far more common — are live attenuated vaccines. Here the virus is manipulated in the laboratory to reduce its virility.

New methods

With the new biotechnology other production methods are available. In 1975 monoclonal antibodies were developed. These are designed to recognise a particular protein or proteins — the so called epitope — involved in the antigenic response.

Similarly if the amino acid sequence of the epitope is known it can be reproduced synthetically and used to evoke an antigenic response in a host, conferring immunity.

A third method is to manipulate the expression of a gene such that the



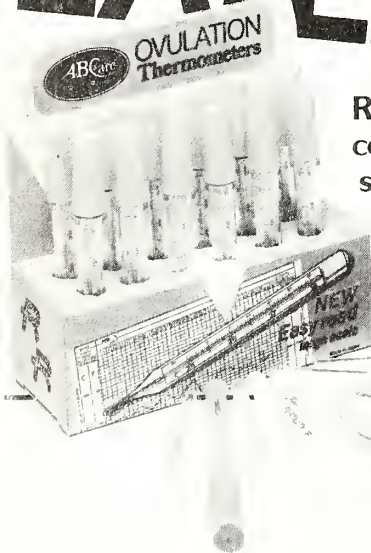
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antigenic principle is produced by a cell, be it the virus itself, such as vaccinia virus, a yeast cell or mammalian cell.

Live attenuated vaccines may be produced by manipulating genes of a virulent virus to produce an avirulent form that will still invoke an antigenic response.

Dr Schild has worked on this method for polio virus. Of 7,000 bases in the genome only nine nucleotide changes are necessary to produce the genetic make up of the attenuated virus used by Salk in his polio vaccine. Only three of these changes are important for attenuation.

The danger with live attenuated vaccines is, of course, that they can revert to virulent forms. Indeed Dr Schild estimates that 1 in 2 million recipients of the poliomyelitis vaccine suffer paralytic poliomyelitis because the virus reverts to its virulent form. Yet only four nucleotide changes are needed in the avirulent form's genome for virulence to re-occur. It may be possible to overcome these problems using modern genetic techniques.

However, simply reproducing the amino acid sequence of the antigenic (or antibody producing) part of a virus does not mean that antibody production will

necessarily be induced in the recipient. The configuration of the molecule is also important so X-ray diffraction studies are sometimes done with crystallized protein to discover its 3-D structure.

Such small parts of the virus are, however, only poor antigens. They have to be linked to carrier proteins which obviously have to be medically acceptable. An adjuvant is also needed to enhance the immune response. Freund's adjuvant is used in animals for this but so far no generally acceptable compound has been found for use in man, although muramyl dipeptides have shown some promise in this respect. There is also evidence that cellular immunity can be as important as antibodies in the immune response. For example, cytotoxic T-cell lymphocytes which engulf and devour foreign cells. Cell and antibody related immunity are involved to varying extents in different diseases.

One area of great promise in vaccine production is that of antigenically modified vaccinia virus which can be used to produce antigens of other viruses by generic manipulation — up to 10 separate pieces of foreign viral genome can be

inserted into the vaccinia DNA. Using the technique it may be possible to produce multi-vaccines allowing immunisation against several diseases with a single vaccine.

Technical problems

However, the technique is not without its problems and has caused some controversy which is to be discussed as part of an international meeting in November. Vaccinia may cause severe reactions in patients with eczema for example. Indeed some authorities regard it as positively dangerous. However, the techniques could be applied using *Escherichia coli* for example, for those viruses that enter via the gut thus producing an oral vaccine.

For diseases such as hepatitis and rotavirus where the viruses have not been grown such manipulations may prove useful in producing the epitope or antigenic element with which vaccines to the diseases could be produced.

Similarly where highly pathogenic viruses are concerned the new biotechnology would allow vaccines to be produced without handling the virus.

The surface antigen in hepatitis has been expressed using yeast cells and has proved a good antigen in clinical studies in man.

Prospects

The genome for these antigens has also been inserted into vaccinia virus and hepatitis B surface antigen has been produced by injecting this into monkey cells giving an immunising effect. This work reported recently in *Nature* represents a landmark in development and the prospects for further progress are now enormous, Dr Schild said.

"Indeed it will probably not be long before hepatitis vaccine made by genetic manipulation is on pharmacists' shelves. But the future for other new vaccines may be further away than we think."

Band Rocket Thermometer Wholesalers

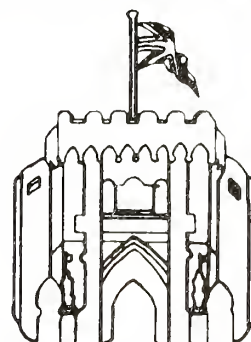
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Chas. Stevens & Co
D.E. Riches
Ayrshire Pharmaceuticals
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Macarthy's
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Cancer cure needs novel approaches

The way forward for cancer chemotherapy must lie in the development of new drugs acting by new mechanisms and on new targets, said Dr A.H. Calvert, Institute of Cancer Research, during Friday morning's symposium.

Commenting on the current state of chemotherapy, he said that cancers range from childhood leukaemia, which could readily be cured, through tumours where cures might be achieved but more intensive therapy was necessary, to ovarian cancer where even intensive therapy resulted in relatively few long term survivors. Results in some other tumours such as carcinoma of the colon were so derisory they hardly merit discussion.

One approach to the problem was to search for more active and selective drugs; other approaches were the use of adjuvants or of high dose therapy. Unfortunately, adjuvant therapy had done little to improve the overall survival rate in advanced breast cancer. High dose therapy, while an advance for certain tumours, was limited by the inherent toxicity and lack of selectivity of the drugs used.

In childhood leukaemia and Hodgkin's disease, limited results could be achieved using single agents, but improvement was dramatic with combination therapy, Dr Calvert continued. By adding intrathecal and central nervous system irradiation to the treatment regimen, most patients were cured. Studies had identified various prognostic factors. Patients who were under two or over 13 years old tended to fare badly. Those whose tumour cells displayed T cell or B cell markers also had a poor prognosis, as did those whose total white cell count was extremely high on diagnosis. The identification of these prognostic factors allowed therapy to be better tailored to patients.

Cisplatin had been a significant advance in the treatment of testicular teratoma, Dr Calvert continued, and the regimens used at Charing Cross Hospital had resulted in an 80-90 per cent cure rate. This drug had also improved the survival rate for patients with ovarian cancer but the number completely cured was still not high.

The severe side effects of cisplatin — vomiting, kidney damage, deafness and peripheral neuropathy — had led to a search for safer analogues. One of these,

carboplatin, had been tried successfully at the Royal Marsden Hospital, London, where it had produced a similar response to cisplatin in advanced ovarian cancer and was much less toxic.

Talking on strategies for the discovery of new anti-tumour drugs, Professor M. F. G. Stevens, professor of experimental chemotherapy and head of the pharmacy department, Aston University, said that innovation would be most likely to result from several disciplines — pharmacists, chemists, biochemists, molecular biologists, etc — working together and exchanging ideas.

Current drugs were unselective and the toxic consequences for the patient could be worse than the original disease. Much-acclaimed advances in molecular biology had yet to prove successful in the patient, said Professor Stevens.

The National Cancer Institute in Maryland had screened about 400,000 chemical entities for antitumour activity, yet there were only about 40 clinically-used drugs. However scientific one tried to be, the discovery of genuinely new compounds still remained the province of random screening. For example, the compound mitoxantrone hydrochloride, recently launched by Lederle as a possible alternative to adriamycin in breast cancer, was originally used as a Biro ink.

Because screening in humans is impossible, a suitable test system was needed which was cheap, reproducible and predictable for clinical activity, and which would detect selectivity. None of the test systems used at present fulfilled these criteria. It was possible to implant fragments of human tumours into mice, but the results had still been disappointing in predicting clinical activity.

One approach in research was to develop analogues of existing compounds

with a view to increasing effectiveness, reducing toxicity, improving bioavailability or targetting of the drug. An example was Astra Z 7557 which broke down to the same active metabolite as cyclophosphamide but was able to remove the toxic acrolein molecule produced at the same time.

Another approach was to inhibit a crucial biochemical pathway unique to the cancer cell. But normal proliferating cells and tumour cells shared a common cellular biochemistry and drugs were unselective. Tumour cells also had the ability to become resistant. Although such biochemical inhibitors would probably not be the overall cure for cancer, Professor Stevens thought they might be valuable probes with which to explore "some of the darker secrets of the cell."

A further approach was to try to reform cancer cells back to normal rather than kill them. N-methylformamide could reform malignant cells but at concentrations that could not be reached clinically. It might, said Professor Stevens, prove successful combined with other drugs.

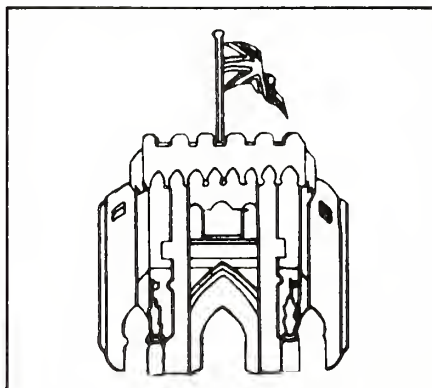
Drugs might also be developed that attacked targets which controlled cell growth, or disorganised the lines of communication between tumour cells.

Professor Stevens went on to describe mitozolomide, a drug developed at Aston in collaboration with May and Baker. It appeared to be a pro-drug whose active compound reacted with nucleic acids, and it was about to enter phase-two clinical trials in several countries.

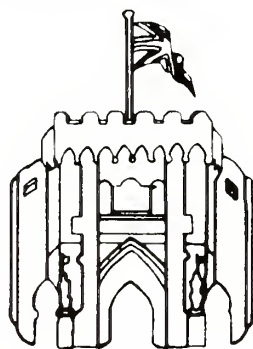
When asked during the discussion about the role of monoclonal antibodies, Professor Stevens said that using these agents to target drugs was a good idea but they would not transform a modest drug into a "world beater." Researchers at Aston were about to start a collaborative project with researchers at Nottingham University, linking mitozolomide to tumour specific monoclonals.

Conjugates with ricin had proved disappointing, Professor Stevens said, and there was a long way to go before the right molecule for targetting was developed. Dr Calvert also explained the difficulties involved in making the monoclonal antibody attach to the tumour cells.

Asked about the state of cancer-research funding in the UK, Professor Stevens replied that the Aston group was fortunate to have enough resources, being generously supported by the Cancer Research Campaign and having links with industry. Other groups, trying to obtain their first grants, were having problems finding resources. There was a need to invest money in a co-ordinated, multidisciplinary approach in the hope of generating new ideas.



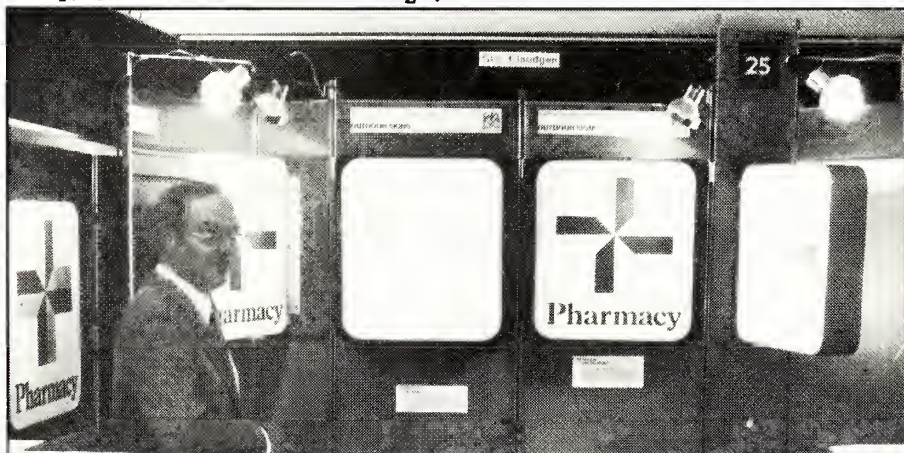
Pictures at the Exhibition



1 ▲

2 ▼

1. Warner-Lambert product manager Ms Nadia Amini gets the company message across to Mr Roy Dobinson, a hospital pharmacist from Brisbane, Queensland, Australia and his wife Kathleen. 2. GEC Claudgen marketing manager Mr Gage surveys his company's stable of signs carrying the Pharmaceutical Society's new pharmacy logo. The company is the sole licensee. 3. Concentrating on oxygen concentrators on the De Vilbiss stand are company representatives Martin Winter (centre) and Paul Piggott (right) with Peter Ridgway-Watt, Beecham Pharmaceuticals.



3 ▼



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Medicine in the Tudor age

Tudor drug jars found in Southampton, Tudor surgical techniques, and the Mary Rose, were the subjects of talks given at the History of Pharmacy session last week

The prevalent enthusiasm to consider drug jars as artistic examples had bedevilled medieval archeologists in their efforts to fill gaps in the knowledge of the period, said Mr R.H. Thompson, Keeper of Archeology and Antiquity, Tudor House Museum, Southampton, during his talk on "Drug Jars and Medieval Trade in Southampton." There was a great deal of information covering the Tudor period, but earlier details were scanty.

It was known that a Mediterranean galley had fought Southampton inhabitants in 1327 but from that time there was a gap which remained to be filled.

It was also known that Southampton had been involved in Mediterranean trade during the medieval period but evidence was meagre and difficult to ascertain. The drug trade evidence from albarello was "not of great antiquity" merely going back to the 15th century!

New techniques were being developed by archeological scientists using new analytical procedures whereby scrapings from the insides of containers were investigated to ascertain possible contents. This was painstaking work. In a recent trial of 40 fragments submitted for examination, 39 gave negative results and the other indicated "probably olive oil." It was not good looking at museum specimens, "they had all been carefully washed."

Now in Southampton they examined pots as they came out of the ground, before washing, for clues of contents.

Southampton archeologists had the advantage of the fact that the port had operated on three different sites at different periods of history. The medieval site had yielded a specimen of gold leaf with a heavy trace of mercury applied to a piece of stone. It was known that the metals were available from Spain or Persia at that time. Mr Thompson believed the site would yield more evidence as the investigations continued.

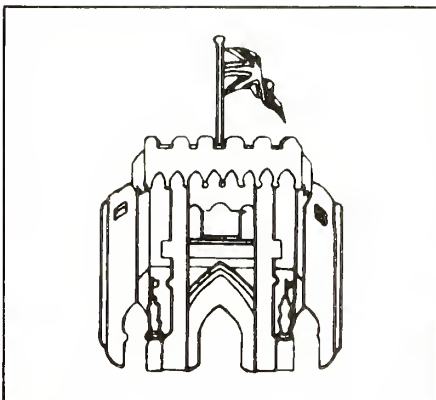
At Romsey, near the cathedral, a small

group of pottery had been found with glaze of a type used in South West France. Cone-shaped jars which had been found "all over the world" had an inner glaze but none on the outer surface, indicating it was applied to protect the contents. They were known as Spanish olive oil jars and although to modern eyes the shape appeared unusual, it had to be realised that such shapes could be "stacked beautifully." The speaker showed a slide of two heavy pots about 3½in high, only one of which was glazed. Analysis of thin sections of the pottery showed the pots were from two distinct geological areas, one Spanish and the other Persian. Could these be the first authenticated mercury jars? It was possible that there were lots of jars that were not readily recognisable as drug jars since records had shown that pepper, colocynth, waxes, resins, sulphur and treacle were being imported.

The second paper of the session was given by the Vice-Admiral Sir James Watt, president of the Royal Society of Medicine. Its title was "Tudor Surgery and the Mary Rose." Sir James pointed out that Henry VIII was an extremely educated individual, skilled in mathematics and music. He was also a linguist, speaking four languages. The King also recognised that there was little opportunity for a rural country to progress unless it developed its trade. In medieval times battles, even on ships, were chiefly between swordsmen and archers. It was Henry VIII who developed the ship into a fighting weapon with its broadline gunnery. Many surgeons at the time practised "Salerno school of medicine," removing foreign matter from wounds, cleaning and then allowing healing by first intention.

Sir James showed slides of surgical instruments of the period contrasting the ornately carved handles typical of continental manufacturers, with the severe utilisations specimens produced in Britain.

The session was chaired by A.G.M. Madge, president of British Society of the History of Pharmacy, who in his opening remarks mentioned the great loss the Society has sustained by the death of Mr Robert Todd.



Professor J.T. Smith (left) this year's conference science chairman investing the 1985 Conference science chairman Professor J.D. Phillipson



Dr Michael Jepson (right) receiving the Rybar award of £100 from Dr Hopkin Maddock, Pharmaceutical Society president. The prize, for the best poster presentation at conference, was won by Dr Jepson and Alison Morley, both members of the practice research group at the University of Aston in Birmingham

Gut reaction on drug metabolism

Drug metabolism in the gut can lead to differences in pharmacological effects between different individuals, said Professor C.F. George, University of Southampton.

Speaking at Wednesday's plenary lecture he explained that drugs could be broken down either by mucosal enzymes or by intestinal bacteria, leading to differences in bioavailability. Significant drug interactions could also occur.

Outlining work done at the university on cardiovascular drugs, he said that isoprenaline, methyl dopa, hydralazine and nifedipine could all undergo metabolism by enzymes. Digoxin was broken down by gut micro-organisms and after antibiotic therapy serum levels increased markedly, leading to toxic effects. Sulphinpyrazone was also degraded by bacteria.

The micro-organisms responsible seemed to be various strains of *E. coli* and *Bacterioides fragilis*.

Pharmacy legislation since 1900

At the beginning of the present century much criticism was directed at the industry which had by then grown up to supply proprietary medicines. The British Medical Association in particular attacked the popularity of the secret remedy: "... there is for the average man or woman a certain fascination in secrecy. The quack takes advantage of this common foible of human nature to impress his customers. But secrecy has its other uses in his trade; it enables him to make use of cheap, new, or old fashioned drugs, and to claim that his product possesses virtues beyond the ken of the mere doctor".

That statement was included in the preface of a book "Secret Remedies, what they cost and what they contain" (1909) based on analyses made for the BMA. Besides disclosing the formula, the BMA estimated the cost of the ingredients of the analysed medicines and the claims made for the preparations. A further volume was published in 1912. Thus an atmosphere was created to build up a demand for an official investigation into the sale of medicines.

A Select Committee on patent medicines was formally inaugurated by Parliament on April 25, 1912 to inquire into the "sale of patent and proprietary medicines and medical preparations and appliances and advertisements relating thereto, and to report what amendments, if any, in the law are necessary or desirable." Sir Henry Norman was elected chairman of the committee which included Mr W.S. Glyn-Jones. The minutes of the evidence taken before the committee were published in October 1914 in a Blue Book of 782 pages which weighed nearly 4½lbs. This publication was issued later than the Report which was released during the

Last week in our 125th anniversary issue (p488) we reviewed pharmacy legislation from C&D's founding to 1900. This week takes us from the turn of the century to the present day

August of that year.

The Committee stated that £2 million were spent annually in advertising secret remedies. It also declared "for all practical purposes British law is powerless to prevent any person from procuring any drugs or making any mixture whether potent or without any therapeutical activity whatever (so long as it does not contain a scheduled poison), advertising it as a cure for any disease or ailment, recommending it by bogus testimonials and the invented opinions and facsimile signatures of fictitious physicians and selling it under any name he chooses — on the payment of a small stamp duty — for any prices he can persuade a credulous public to pay."

Government controls

Although it was becoming increasingly evident that there should be some government control over the sale of medicines and claims of therapeutic efficacy, nothing more was done until 1920 when Viscount Astor introduced the Proprietary Medicines Bill into the House of Lords on July 13, 1920. Nobody was to be allowed to manufacture

A 1901 draft of a Bill to regulate the sale of poisons and amend the Pharmacy Acts of 1852 and 1868: the Therapeutic Substances Act, 1925 is also pictured.

proprietary medicines unless registered under the Act and the sale of any unregistered proprietary medicine was prohibited. It was to be unlawful to sell any medicine or surgical appliance purporting to prevent cure or relieve cancer, consumption, lupus, deafness, fits, epilepsy, (amenorrhoea), or other diseases peculiar to women, diabetes, paralysis, locomotor ataxy, Bright's disease or rupture.

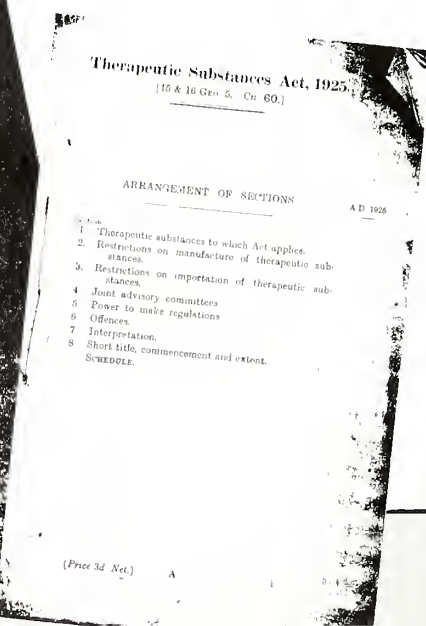
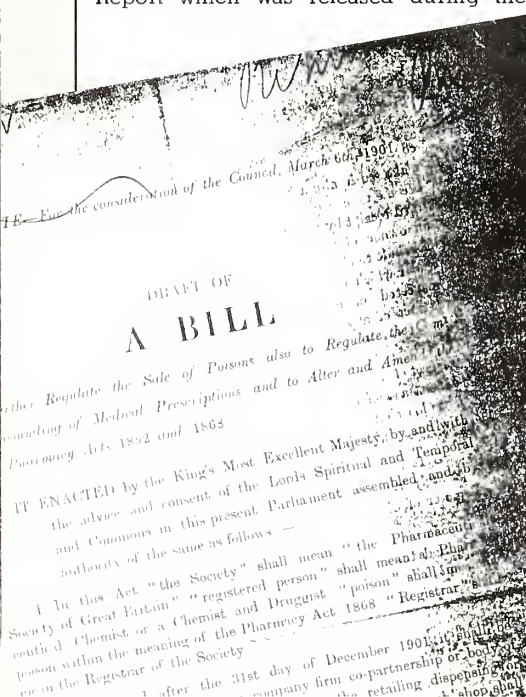
The Bill affected not only the large manufacturers of advertised medicines, but also the chemist who made and sold his own proprietaries. Many amendments were submitted. The Chemists Defence Association, the Association of Manufacturers of British Proprietarys, and the Proprietary Articles Section of the London Chamber of Commerce all actively opposed sections of the Bill and it was finally shelved.

During 1931 Dr Hastings introduced in the House of Commons another Proprietary Medicines Bill. Its scope was similar to the earlier Bill and many deputations of pharmacists converged on Westminster to indicate their objections to the Bill, which was also withdrawn.

On March 27, 1931, during the second reading of the Medicines and Surgical Appliances (Advertisement) Bill in the House of Commons, it was stated that the Bill represented the greatest measure of agreement that had ever been obtained on the problem. Bodies that had expressed approval of the Bill included the BMA, NPU and the Wholesale Drug Trade Association. An amendment was moved and seconded that the Bill be read "upon this day six months" but shortly after the next speaker had begun to address the House, attention was called to the fact that 40 members were not present and the House was "counted out".

Another Select Committee was appointed in 1936 to consider the medicine stamp duties. The terms of reference differed from those given to the 1912 Committee, being so worded as to give prominence to the advertising aspect of the problem. Now the emphasis was on "the duties of excise chargeable". The C&D editorial comment following the issue of the report on February 26, 1937, concluded: "This report perhaps presents the most devastating view on the position of pharmacists in this country which has ever been formulated."

The Committee considered that the law should be simplified and stated they were of the opinion that the trade in medicinal articles was suitable for taxation and that it was undesirable that the same product could be sold by different vendors stamped and unstamped. "Should the control of the trade in medicines and appliances be deemed



desirable for the protection of the public the Committee believe that the best method of achieving this would be a system of examination and registration . . ."

A section of the report which was distasteful to pharmacists stated: "There was considerable divergence of evidence regarding the additional safeguard to the public which is provided by the presence of a registered pharmacist on premises where there are large sales of ready packed medicines. Your Committee, however, take the view that this protection is in many cases illusory and they are, therefore, not prepared to put the value of such a safeguard very high."

The Budget of 1939 contained a recommendation for the repeal of the medicine stamp duties but because there was no compensating legislation for chemists who were to have lost their advantages of selling unstamped remedies free of duty, much opposition was raised in Parliament and the discussions recommendation was not proceeded with.

More discussions continued between those interested in the trade and in July 1941, a Pharmacy and Medicines Bill was introduced in Parliament. The purpose of the Bill was to repeal the medicine stamp duty

and the associated licence duty, to prohibit advertisements relating to certain diseases, to regulate the sale of medicines and to effect some minor amendments to the Pharmacy and Poisons Act 1933. In the main it allowed the free sale of proprietary medicines without duty or licence provided there was a declaration of composition.

Control of the 'irresponsible'

Although the Medicine Stamp Acts had more effect upon the distribution of medicines than possibly any other piece of legislation there were other Acts which had been used to control the irresponsible.

The Sale of Food and Drugs Acts 1875, 1879 and 1900 made it an offence to mix a drug with ingredients which injuriously affected its quality and potency, and to sell a drug so mixed, or to sell food or drugs which were not of the nature substance and quality demanded. The systematic purchase of test samples by members of the Local Government Board was set out. Throughout the years, this legislation has comprised one of the most important of regulations concerning quality standards.

The Merchandise Marks Act 1887 was used very soon after its introduction by

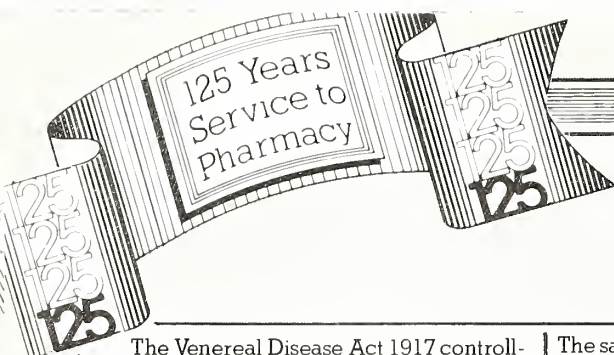
public prosecutors for the punishment of persons selling adulterated goods. Prior to the introduction of the Act misrepresentation had been looked upon as a wrong inflicted on an individual who was entitled to redress for the injury he had sustained. The 1887 Act made it an offence to have in possession for sale or for any purpose of trade or manufacture, any goods to which a forged trade mark or false trade description was applied.

Another Act controlling therapeutic substances must not be overlooked. In April 1920 the Minister of Health, Dr Christopher Addison, appointed a Departmental Committee to consider and advise upon the legislative and administrative measures to be taken "for the effective control of the quality and authenticity of such therapeutic substances as cannot be tested adequately by direct chemical means." The outcome was the Therapeutic Substances Act 1925, controlling vaccines, sera, preparations of insulin and pituitary.

Later, with the coming of penicillin, the Penicillin Act was introduced. Similar legislation controlling various antibiotics was issued and the references became somewhat numerous. So the Penicillin Act and Regulations were consolidated into the Therapeutic Substances Act 1956.

Who's the world's largest dry cell battery manufacturer?





The Venereal Disease Act 1917 controlled the treatment of venereal disease and advertisements relating to the disease. The Cancer Act 1939 prohibited the publication of certain advertisements relating to cancer.

The Acts just mentioned have played their part in the control of the distribution of medicine, each acting like the Dangerous Drugs Acts in what might be termed a specialised way, but the one Act which, when introduced, began to affect medicine as a whole in this country was the passing of the National Insurance Act in 1911 and the resulting National Health Insurance in 1912. By this the majority of general practitioners and pharmacists became accustomed to some degree of control by public administrative machinery.

There was also an important change in the distribution of medicine. Prior to the Act many doctors prescribed and dispensed medicines and even after the Act the family doctor would usually give prescriptions when treating the husband — but if his wife of children required attention the doctor would dispense "bottles of medicine". Within the framework of the Insurance scheme there was built up machinery designed to control excessive prescribing, but there was no special attempt to control the prescribing of advertised medicines.

The rise of the pharmaceutical industry during and after the 1914-18 war was accompanied by a scientific revolution in pharmacy — the introduction of specific synthetic drugs and antibiotics. Parallel with those scientific achievements were the commercial developments — the emphasis on selling and packaging together with the growth of advertising, and widely advertised products helped to create a drug conscious public. At the same time the ethical or dispensed proprietaries became more numerous so that by the time the "all embracing" National Health Service was introduced during 1948 the scientific and commercial developments in pharmacy which had revolutionised the industry were reaching a high level.

Reference has been made to the legislation which controlled advertisements connected with specified diseases. The Food and Drugs Act and Merchandise Marks Acts also prohibited misleading advertisements.

This legal control was supplemented by a comprehensive system of voluntary control which had gradually been set up by manufacturers and advertising interests.

The Proprietary Association of Great Britain, supported by the manufacturers of publicly-advertised medicines, introduced a code of standards of advertising practice in 1936. There was also the code of standards relating to the advertising of medicines and treatments which is applied by advertisers, and their agents and supported by the Press.

The same Code has been adopted by the advisory committee of the Independent Television Authority in Britain.

Another example of such voluntary control was that of the standards committee set up within the Chemists Federation organisation fostered by the National Pharmaceutical Union. A more recent system of voluntary control was that formulated within the aegis of the Association of British Pharmaceutical Industry relating to the introduction of new ethical preparations. This was stimulated by the criticism that the pharmaceutical industry had received in connection with the rising costs of the National Health Service.

Although the repeal of the Medicine Stamp Duty came about after much negotiation in and outside Parliament, medicines were not to remain untaxed for long. The Finance Act introduced Purchase Tax, which brought a 25 per cent duty on most medicines although certain "dispensing packs" meeting strict criteria were exempt. The packs were available only to authorised sellers of poisons, hospitals, doctors, dentists and veterinary surgeons. In addition a restricted list of drugs and medicines were exempt. These included insulin, hormones, vaccines, sera and vitamins. That situation continued until Purchase Tax was replaced by the Value Added Tax introduced in 1973.

Re-orienting

When the *C&D* celebrated its centenary in 1959 a position had arisen which was not in some ways dissimilar to that which applied at the beginning of the 19th century. Medicines were still largely sold through non-pharmaceutical channels and there appeared to be no immediate signs of a rigid governmental control by either a system of product registration or independent approval.

The legislation which was having probably the greatest influence on the distribution of medicines was legislation like the old Stamp Acts, that was primarily introduced for purposes older than the control of medicines. The Trade Marks and the Patent Acts were continuing to play an increasing part in the marketing of medicines. There was still a tendency to connect the control of pharmacy as a profession with poison law legislation and that legislation had developed somewhat haphazardly. It needed reorienting.

Another legislative problem was that the Pharmacy and Poisons Act controlled not only poisons used in medicine but also those substances when involved in industrial and manufacturing processes. Farmers were becoming involved with "growth promoters"; horticulture was using an ever-increasing variety of synthetic compounds; the

REPORT FROM THE SELECT COMMITTEE ON MEDICINE STAMP DUTIES

TOGETHER WITH THE
PROCEEDINGS OF THE COMMITTEE, MINUTES
OF EVIDENCE AND INDEX, ALSO PROCEEDINGS
OF THE SELECT COMMITTEE ON MEDICINE
STAMP DUTIES, SESSION 1935-6

Ordered by The House of Commons to be Printed
18th February 1937

chemical industry was expanding, and organic chemists becoming extremely inventive. Thus a new approach was needed to ensure the controls were appropriate, effective and matched the changing situation.

There was also a growing problem of the misuse of drugs. Legislation was enacted to meet a problem that had become evident. Rarely, if ever, was legislation in force to avoid or prevent a misuse situation. In 1956 the widespread abuse of amphetamines brought Home Office action making them prescription only drugs. Nevertheless, the problem remained, primarily as the result of over-prescribing. The 1964 Drugs (Prevention of Misuse) Act made unauthorised possession an offence and enforced import and export controls. Regrettably the amphetamine difficulties continued. The control of narcotics was also being thwarted.

In the early 60s an increase in drug addiction was investigated by the Brain Committee leading to the 1967 Dangerous Drugs Act, which made it compulsory to report heroin addicts, and imposed additional controls on prescribing of drugs of dependency.

However, the laws did not provide a comprehensive scheme for controlling all aspects of misuse. None dealt sufficiently with trafficking, and there was no method of speedily dealing with irresponsible over-prescribing of dependent drugs. The current Misuse of Drugs Act 1971 and Regulations attempted to fill in those gaps. They enabled the Home Secretary to act quickly in cases of over prescribing. Unfortunately the problem of the too oft repeated prescription is still with us.

While many changes in the developing pharmaceutical legislation have been noted, legislation of a general nature has also been extended, and the practising pharmacist has now to be aware of legislation concerning the sale of goods, contracts, consumer credit, Shops Acts, employment, sex discrimination, health and safety at work, and race relations. Pretty formidable!

The circumstances in which a chemist and druggist operated 125 years ago are thus vastly different from those of his successor, but their basic activities of serving the public generally and the patient in particular has remained unchanged. The two new features, the vast NHS and the growing science of technological medicine, are likely to exaggerate the differences in future decades, and at the same time attract an even greater variety of legislation.

OPEN SHOP

By a Southern Counties proprietor

Distribution — confusion in Wonderland?

"... then the bowsprit got
mixed with the rudder
sometimes"

Lewis Carroll

I often find myself in an Alice in Wonderland miasma when I contemplate situations which arise in the world of pharmacy. The latest rabbit hole into which I have fallen revolves around the recent amendment to the Medicines Act — The General Sales List Order, June 1984.

As one stalwart correspondent to the columns of this journal pointed out, we all thought the Medicines Act was intended to regulate the distribution of medicines to the public by controlling the supply through channels where a sense of social and professional responsibility prevails (ie. pharmacies); thereby protecting the public from unscrupulous marketing and, not least, themselves. We were wrong it seems. This basic concept is in the process of being dismantled piece by piece.

The June conference of the European Proprietary Association (the big brother of our Proprietary Association of Great Britain) announced boldly that it looks forward to a deregulated future. Self medication is to expand — "the issue is now to the forefront in Europe" — and I fear the pharmacist does not occupy quite such a pivotal position as he may imagine in the scheme of things in this country at least.

Several rather questionable statements were made during this conference: "...the substances used in OTC medicines were well known and long proven and the consumer would not have continued to buy a product that had side effects", and again "the purposes for which such medicines were used were so limited as to guarantee a certain level of safety". Perhaps more significant was the assertion that "doctors probably did not object to general sale proprietaries but many opposed an increase in ethical pharmacy only products".

The new General Sales List Order categorises a product GSL on the basis of ingredient and the mesh of the net has significantly increased. Robitussin is just one example. The NPA "Ask Your Pharmacist" campaign, will become of little value if the bulk of the shoppers' medicine wants are on the shelves of the grocer and supermarket. Not only that, GSL items may now be merchandised from coin-op machines. Is the Medicine Automat too far away? Already

Shell and Ultramar tell us that selected service stations will offer a limited range of household medicines from their shops — open from 7am to 11pm.

Just to add a little confusion, the DHSS tells us that although a product on the shelf of your pharmacy carries the P symbol, it may legally be GSL; and that licence holders should continue to label such items as P. Perhaps that makes sense if we read it standing on our heads.

Surely we deserve to know who makes these decisions and to be told the rationale for a particular change in classification. At present, the edict is handed down as on tablets of stone. We spend valuable years studying the action of drugs and yet we are treated as some ill informed group who simply need to be told what to do. The Gas and Telephone Consumer Councils have a better deal. Is there no place for effective consultation and explanation? At what stage is the National Pharmaceutical Association and Pharmaceutical Society of Great Britain brought into the picture? Perhaps our Council could more profitably spend time deliberating on the distribution of medicines, than investigating the adhesive for sticky labels.

HEALTH CENTRE NEWS

Dewsbury Health Authority. West Yorks proposes an extension to the health centre at Town St, Birkenshaw near Bradford.

Mersey RHA: A health clinic is to be erected at Hope Farm Rd, Ellesmere Port and approval is sought for a single storey extension to the Phillips Lane Clinic in Formby, Lincs.

Central Nottinghamshire Health Authority. A new £770,000 health centre is planned within the proposed Slaughterhouse Lane Scheme. Permission is being sought for a health centre and parking facilities at junction of Carlton Rd and Randolph St, Nottingham for Doctors Sood, Laughlin and Arden-Jones.

South East Thames RHA proposes a new health centre at Seaford, Sussex with part single-storey, part two-storey facilities for ten GPs plus services facilities. The building is estimated to cost £800,000 with another £300,000 for mechanical and electrical engineering.

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Fines imposed on two firms

Two chemists firms have been found in breach of their terms of service and fined after investigations by the Birmingham Pharmaceutical Service Committee.

In the first case, Mogadon tablets were dispensed instead of Paramol on a prescription calling for both. The patient suffered a fall as a result and was subsequently found to have a broken arm. The firm was reprimanded and fined £100.

In the second case, routine drug testing discovered a prescription calling for 30 bendrofluazide tablets had been dispensed with only 20. A reprimand was issued and £50 withheld from the firm's remuneration.

Both decisions were ratified by the Family Practitioner Committee and later upheld by the Secretary of State.

Complaint upheld on ginseng ad

The Advertising Standards Authority upheld a complaint from a Dorset pharmacist regarding an advertisement for pure formula "H" Chinese ginseng by the Herbal Research Group published in *Running* magazine.

The advertisement claimed that daily intake of the preparation would "Improve your body balance and your personal best" and was "a must for all athletes/cyclists."

The pharmacist pointed out that no proof exists to substantiate the claims, which the ASA say are in contravention of Appendix D, 11 of the Code of Advertising Practice, relating specifically to ginseng and its alleged effects. There was also no warning about the effects of long-term usage.

The Group were requested to withdraw their advertisement.

■ The US House of Representatives has approved legislation which will extend patent protection for branded drugs by up to five more years than at present. It will also make licence applications for generic drugs simpler. A similar Bill has already been approved by the Senate. It is widely expected President Reagan will sign the legislation, according to reports in the *Financial Times*.



While Tom Eaton, managing director of Numark wholesaler E.H. Butler & Son Ltd of Leicester surveys the trophy, Owen Jones, MPS, and John Somerville (left), Nicholas Laboratories manufacturing manager turn their attention to the camera. Owen, as winner of the last regional round for the Rennie Trophy, now goes through to the Numark Chemist National Golf Final

CE tenders to PSGB please

The Pharmaceutical Society is seeking tenders for a project on continuing education (CE).

The Society is firmly committed to continuing education but feels the current involvement of most practising pharmacists is "less than it would wish."

There are indications that only 10 per cent of pharmacists take an active part in CE. The Society recognises that many pharmacists may find it more convenient

to study in their own time at home. Indeed research in Ontario, Canada, has shown that distribution of distance learning material increases participation.

The Society wants to conduct a pilot study involving about 3,500 pharmacists in one region over no more than two years with a budget of £50,000 to £100,000.

So far "a staggering number of inquiries" have been made about the project — the majority by organisations outside pharmacy. But obviously some links with pharmaceutical expertise would be needed to conduct the survey. The closing date for tenders is October 26, details from Mr S. Southwell at PSGB.

EEC directive

The first Directive under the European Economic Community's consumer programme, on misleading advertising, has been formally adopted by EEC ministers.

Intended as protection against misleading advertising, the directive instructs member states to ensure adequate measures exist including arrangements for legal action if necessary.

Legislation for implementation in the UK will be put before Parliament in due course. The Government proposes new powers for the director general of fair trading as a back-up to the existing arrangements of the Trade Descriptions Act 1968 and the self-regulatory system of the advertising industry operated through the Advertising Standards Authority and the Code of Advertising Practice. The director general would be empowered to seek court orders prohibiting publication of misleading advertisements in cases where other means were unsatisfactory.

BNF no 8 . . .

The eighth British National Formulary (£5.40 including postage and packaging) was published recently and now includes a list of telephone numbers for drug information services. Other changes include rearranged sections on insulin preparations so that the major distinction is made between rapid-acting soluble preparations and the suspensions that give a sustained or delayed action. Other sections in chapter 6 have been revised notably those on thyroid and anti-thyroid drugs. The section on guidance on prescribing now includes information on prescribing in terminal care and

emergency supply of Prescription Only medicines. The list of dental preparations that can be prescribed by dentists on form FP14 (GP14 in Scotland) has been amended. BNF number 8 (1984) is available from the *Pharmaceutical Press*, 1 Lambeth High Street, London SE1 7JN.

. . . M&P Guide (4)

The fourth edition of the Medicines and Poisons Guide (£5.50 including postage and packaging) was published recently. It takes the same form as third edition and is available from the *Pharmaceutical Press*, 1 Lambeth High Street, London SE1 7JN.

Chemist & Druggist 22 September 1984

Unichem go all-sundries at Sheffield depot

Unichem are centralising their national distribution of chemist sundries at Sheffield. That branch will hold only sundries, with other business being transferred to either Leeds, Hinckley or Preston.

"Our sundries business is very important to us and our members" says operations director Kelvin Hide. "We believe that by devoting a whole branch to the operation we will be able to provide a major expansion of the range."

The sundries service currently operated from Exeter and Newcastle will

be discontinued, Unichem promise no change in service for the 200 customers currently served by Sheffield.

They plan to start transferring orders in mid-October, with sundries stock coming in towards the end of the year. Sundries deliveries should also be unaffected.

□ Unichem have ordered a further 5,000 Hugin Micronic hand-held data terminals, as used in Prosper order assembly and transmission. According to Hugin, the PDTs are to be supplied over the next three years, and are in addition to the 3,000 already supplied. Delivery starts in December.

Major US buy for Reckitts

Reckitt & Colman are making their first-ever rights issue to raise £106m for at least one major household products acquisition in the US.

The one-for-five issue will also be used to finance expansion within the existing group. Company Secretary David Clifford says R&C have recently been financing

such growth by means of productivity improvements, strict capital control and disposals. "But you can't go on milking that cow forever."

R&C directors say that acquisition possibilities currently under consideration include "more than one significant international business of such a size that acquisition would be conditional on shareholders' approval."

Under Stock Exchange rules, shareholders must approve the purchase of a company whose price exceeds 25 per cent of the buyer's net assets.



A group of pharmacists and staff from hospital and community practice represented the Cambridge branch of the Pharmaceutical Society at the Cambridge "fun run" recently. The National Pharmaceutical Association supplied "Ask your pharmacist for advice" T-shirts for the team members, who raised £470 for charity

Chemist numbers down in Eire

Total number of retail outlets in the Republic of Ireland increased by 7.3 per cent in the five years to 1983. But the number of chemists fell 5.6 per cent in the same period.

A.C. Nielsen listed 37,312 outlets in 1977, a figure rising to 40,022 by 1983. There were 1,132 chemists in 1983, compared to 1,199 five years earlier. Food outlets were also down, showing a 6 per cent decline over the period.

All outlets showed a trend towards town-centre developments. The five years show a 13 per cent increase in number of outlets in large towns (6,000 + population), a 10 per cent rise in small towns (1,000 +) and a drop of 3 per cent in rural areas.

Marketing Research — Republic of Ireland, available free from A.C. Nielsen of Ireland Ltd, 36 Merrion Square, Dublin.

Hawaiian move

Hawaiian Tropic part company with distributors Chesebrough Ponds on November 30.

The company are putting together their own salesforce for the 1985 season. "We have decided to make the split due to both our companies having ambitious new product programmes which could result in a conflict of interests," says CP marketing director Roy Gayton.

Revlon unite

Revlon are bringing together their international cosmetics, toiletries and fragrances divisions to form a world-wide beauty group.

Company chairman M. Bergerac says the change will allow Revlon to unify and strengthen their marketing activities to become "even more competitive." The new group will be headed by Paul Woolard, currently president of the US cosmetics and fragrances division.

CARNATION

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Chemex claim success in '84

Chemex 84 attracted over 5,000 visitors to examine the wares of the 250 companies there.

Busiest day was Sunday, when there were some 3,600 visitors, though some exhibitors said more actual business was done on Monday.

Organisers Trade Exhibitions describe themselves as "very happy" with the response. The children's play area catered for nearly twice as many kiddies as last year, leading Trade Exhibitions to believe they succeeded in getting "Mrs Chemist" to come along.

■ **Edinburgh wholesaler Raimes Clark** is the oldest pharmaceutical wholesaler in Scotland, as stated on p483 last week. However, the company has no connection with Vestric and is as independent now as it was when it moved into its present premises in 1832.

Prism seminars

Unichem are holding a series of seminars on their Prism computer system.

They are to be held around the country in the evening and admission is by invitation only. Details and tickets from Unichem on 01-391 2323.

Wednesday, September 26

Wirral Branch. Pharmaceutical Society. postgraduate medical centre, Clatterbridge Hospital, at 8pm. A talk on "the Theatre Clwyd." A light supper will be available and anyone requiring it should ring Mrs Chantler on 051-342 2344

Thursday, September 27

Plymouth Branch. Pharmaceutical Society. medical centre, Greenbank, at 8pm. Talk by Dr M.G. Davis, consultant dermatologist at Greenbank Hospital, on "Recognition of skin diseases."

Advance information

Welsh Pharmaceutical Conference. St George's Hotel, Llandudno, on October 13-14. Saturday, October 13 for conference dinner from 7.30pm. Sunday, October 14 from 9.30am-4pm. Sessions on "The basis for sole responsibility," "Continuing education for pharmacists in Great Britain," "Research" and "Post-registration developments." Cost is £42 per conference member, £37 per accompanying person, for twin/double or single rooms with bath. Information from Mr S. Southwell, Secretary to the Welsh Executive, Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London. **Effective Marketing Resources.** 64 Park Street, Camberley,

Surrey on October 16-17, and November 7-8. Two-day "pharmaceutical finance workshops" will cover current financial pressures on the industry and their implications, management ratios, working capital and other financial matters. Cost is £287.50 including VAT per delegate. Details from Brian Moore, at address above (tel: 0276 65643).

Industrial Pharmacists Group. Pharmaceutical Society. 1 Lambeth High Street, London SE1 7JN, on October 25. Meeting on "Computer applications in pharmaceutical development, production and quality control." Registration fee is £15 for members, £30 for non-members. Details from Mr R.E. Marshall, at the above address. After the meeting is the presentation of the 1984 R.P. Scherer Award, to Dr D.A. Tansh. Tickets for the presentation and buffet from Mr Marshall.

Newton Communications Ltd. Royal Society of Medicine, 1 Wimpole Street, London, on October 31, at 9.30am. One day seminar on "Rx to OTC — is there really a trend?" Speakers include Alan Smith, chief executive, Pharmaceutical Services Negotiating Committee, John Wells, OBE, director Proprietary Association of Great Britain, and Sir Gerard Vaughan MP. Cost is £130 per delegate plus £19.50 VAT. Forms from Newton Communications Ltd, 28 London Road, Newbury, Berks.

British Distributors of Animal Medicines Association. Moat House International Hotel, Bridgfoot, Stafford-upon-Avon, Warwickshire, on November 1-2. Conference theme "Practice the code." On November 1 is annual meeting and conference dinner, and November 2 is the conference talks including "The new code of practice" and "The new Statutory Instrument." The cost is £82 per member, £90 per non-member for single accommodation. Further information from BDAM, PO Box 54, Tunbridge Wells, Kent TN4 8WX

Cosmetic, Toiletry and Perfumery Association. Royal Albion Hotel, Brighton, December 10/11. An appreciation course in toxicology for the cosmetics industry, covering topics from metabolic pathways, acute toxicity to carcinogenicity and reproductive studies. Cost is £120 per member, £160 per non-member including VAT, accommodation for Sunday night and Monday night, and all meals and refreshments. Numbers limited to 40. CTPA Ltd, 35 Dover Street, London.

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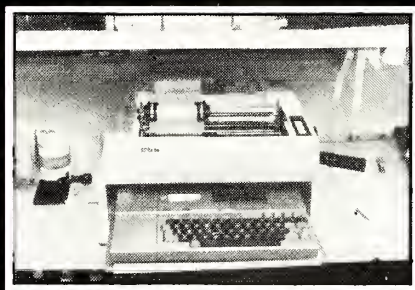
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Retailer Rogers wins C&D Medal

Mr Alan Rogers, a community pharmacist from Claygate, Surrey, won the C&D Medal and Award at the British Pharmaceutical Conference last week.

A director of Ernest Oldcorn Ltd, a small group of pharmacies, Mr Rogers graduated in 1972. As well as being on the committee of his local branch, he is a member of SW Thames Regional Postgraduate Educational Committee and a student member of the College of Pharmacy Practice.



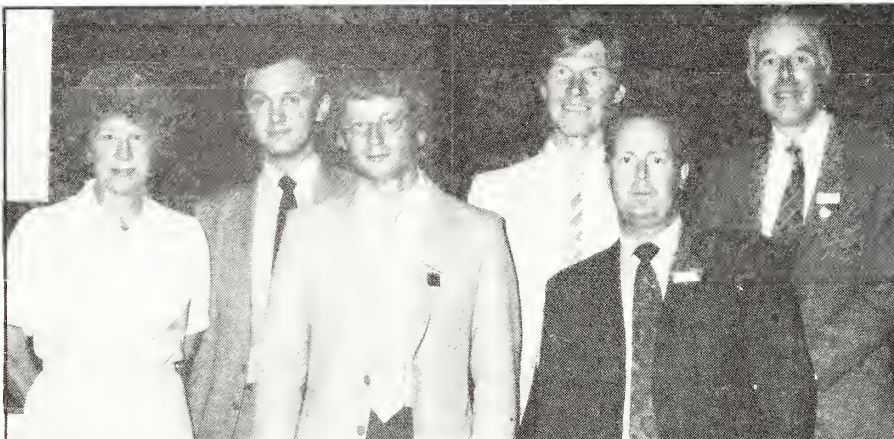
Mr Rogers' winning paper at the practice research session looked at aerosol inhaler techniques.

Success in sponsored climb

Ms Angela Bowman, a pharmacist at Great Ormond Street Children's Hospital, has been successful in a sponsored climb of Mount Kilimanjaro, Africa's highest peak.

She was a member of a team raising money for the Hospital's Sick Children's Trust which provides accommodation for parents wishing to stay overnight while their children are in hospital. The whole party of 15 reached the final camp at 15,000 ft and six, including Ms Bowman, went on to the 19,000ft summit, Dr John Pritchard the consultant organising the expedition, climbed a couple of hundred feet higher to another peak.

Ms Bowman (fourth left, seated) described the climb as "the experience of a lifetime." The team took three days over the ascent and two days to come down, then she went on safari for a few days before returning to London this week. She



Speakers at the practice research session competed for the C&D Medal and Award given for the best presentation of a paper. Left to right: Marion Garner-Patel, Alan Rogers, Brian Wills, Jonathan Cooke, Dr Peter Linley and Graham Hurst

Claire Norfolk, who works at E&M Hazlehurst (Chemist), Bradford, was the winner of the Worth Photofinishers window display competition. First prize was a mini weekend for two in London. Presenting the prize is sales manager Brian Whitaker



APPOINTMENTS

F.W. Woolworth plc: Derek Pretty (finance), Chris French (management information) and Jonathan Weeks (distribution) have been elected to the board.

Scholl (UK) Ltd: Stephen Shearing is appointed general sales manager. He joins the company from Bristol Myers.

A.H. Robins Co Ltd: Frank Stumpf Jr, has been appointed managing director. He has been with the parent company for 15 years and most recently was vice-president and general manager of their operations in the Philippines.

Smith Kline & French Research Ltd: Dr Timothy Rink has joined the company as vice-president for research. He holds degrees in medical science and medicine and surgery.



has not yet collected money from her sponsors so does not know how much she has raised.

Two doctors in the group took dexamethasone after reading reports that it could be useful in altitude sickness. Unlike some of their colleagues they stayed fit, but so did Ms Bowman who was among the "controls."

Holt: Edward Basil of Inglewood, Geeston, Ketton, Stamford, Lincolnshire, died suddenly on September. Mr Holt registered in 1938.

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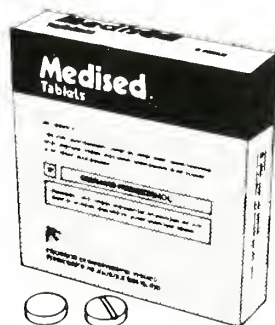


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Single-dose capsules
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sulphosuccinate to
penetrate and soften
wax deposits in the
ear, and to prevent
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becoming clogged.



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feverishness and feverish
colds.

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Provide very welcome
relief for adults who
suffer from the
problems of nasal or
sinus congestion and
pain, particularly at
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